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IMPACT OF BUDGET SHORTFALLS ON THE DELIVERY OF HEALTH CARE TO RURAL VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

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IMPACT OF BUDGET SHORTFALLS ON THE DELIVERY OF HEALTH CARE TO RURAL VETERANS

Friday, December 2, 1988

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Dubin, GA.

The subcommittee met, pursuant to notice at 10 a.m., in the Veterans' Administration Medical Center, Dublin, Georgia, Hon. J. Roy Rowland, (acting chairman of the subcommittee) presiding.

Present: Representatives Rowland and Harris.

OPENING STATEMENT OF HON. J. ROY ROWLAND

Dr. ROWLAND. I would like to call this hearing to order now, and I want to express my appreciation to all of you for being here this morning. I am certainly pleased to have the opportunity to chair this hearing at the request of the Chairman of the Committee on Veterans' Affairs and the Subcommittee on Hospitals and Health Care, the Honorable Sonny Montgomery. It is a particular pleasure for me this morning, because we had to postpone this hearing from our originally scheduled date back in October due to the schedule of the House of Representatives.

We are here today to talk about the mission of the VA medical care system. Earlier this year, the Committee conducted a nationwide survey of VA hospitals to obtain information about their operations. This survey included mainly financial data but also touched on issues of recruitment of health care personnel, acquisition of new and replacement equipment, and maintenance of buildings which house VA medical care.

What we found is that during the last couple of years particularly, the demands for VA care and the costs of running the VA have not been matched with funds. More and more veterans are applying for care for the first time. More veterans are applying for care as they grow older, and the costs of health care keep rising. For the last several years, VA center directors have, in my opinion, performed amazing juggling feats to adjust their budgets to meet demands. They have borrowed from equipment accounts and maintenance accounts to meet the payroll and operating requirements in amounts nationwide of over $105 million for fiscal year 1988. Right here in Dublin alone, there have been well over $500,000 in unfunded operating requirements.

A major question is whether fiscal year 1989 will repeat the 1988 experience. I believe that efforts already started by the House Veterans' Affairs Committee will, I hope, result in supplemental funding for fiscal year 1989, a year in which the VA Central Office itself estimates a shortfall between demands and resources in the neighborhood of $800 million.

In the meantime, we need to be careful about the decisions we make in the short term.

In my opinion, that means we have to be clear about the mission of the VA medical care system, and that discussion is, by necessity, a complex one.

The VA is an important part of the U.S. capacity to deliver health care. It delivers high quality medical services in the most advanced areas of organ transplantation, cancer treatment, and rehabilitative medicine. It is at the forefront of medical research. It participates in the most advanced medical educational programs through affiliation with medical schools, and schools of nursing, and a whole variety of other schools for medical professions.

All of these are important parts of the mission of the VA, but there is another part of the mission, the provision of medical care to rural areas in our country. These are areas that are distant from other sources of medical care and where the VA becomes relatively more important to the beneficiaries.

I want to talk a little about the beneficiaries. About two years ago, for the first time, the Congress created a category of eligibility for veterans for whom the VA must provide care. This category is called "Category A" and consists of veterans who have service-connected disabilities and who are poor. Also included in this category are former POWs, World War I veterans, and veterans exposed to ionizing radiation and herbicides in Vietnam. "Category B and C" eligible veterans have non-service connected disabilities and income above about $15,000 per year. These veterans may receive care but are not required to be provided care by the VA.

The VA, in attempting to deal with the projected fiscal year 1989 budget shortfall, is trying to bring equity to all VA hospitals. The attempt is for each VA Medical Center to deliver care to the required Category A veterans and then to deliver care to the same proportion of Category B and C veterans at each hospital. That is, Dublin should have about 5 percent of its patients as Category B and C patients. Gainesville, Florida should have about 5 percent B and C patients, and so forth. Now, in fact, the intent of Public Law 99–272, which reformed VA health care eligibility was not to eliminate the eligibility of any veteran. Instead, the law was expected to provide a planning basis for the VA, for the Congress, and for veterans, but that is where the funding problem has brought the VA. It is comparable, I guess you might say, to chemistry, for those of you who may have taken qualitative analysis. There is a sudden color change that takes place when you are titrating, looking for a particular unknown or determining the amount of that unknown, and it seems to me that the VA has reached that end point. There have been problems that have been met by VA hospital directors, but this end point, as I say, has now been reached. Part of the response is an attempt to equalize access for various categories of eli-

gibility, and part of the response is to ask regions and districts to think up ways to reduce expenses.

One of these cost-saving suggestions may involve closing surgical units, including the one here at Dublin. Now, Dublin is not the only place that this has been suggested. For that reason, Dublin can, I think, serve as an example. That is another reason that I think this hearing is so very important.

Now, I know that rural areas may cause expenses to rise. It is certainly not cheap or cost effective to run electrical lines into rural areas, or to maintain fire departments in rural areas, or to staff hospitals in rural areas, but the need for that service is there. The need for that service remains.

It seems to me that the VA must be serious about delivery of health care in rural areas. Here in Dublin, we are a good many miles from care in other areas. What happens when the surgical unit is closed? What exacerbations of chronic conditions that require surgical interventions can we expect? What happens to the ability of the Carl Vinson VA Medical Center to recruit staff who want to work in a comprehensive health care system? What happens to the excellence of VA medical care if piece by piece the system is reduced?

So, I say again, we must talk about the mission for the VA medical care system and about the mission for the hospital here in Dublin, and that is what we are here today to talk about.

I really want to thank all of the witnesses who have come today. We have, for the second time, asked them to come down here, and we really do appreciate it. I am always impressed with the dedication of people like you who give so much to public service, and I thank all of you for being here this morning.

Now, I want to introduce my colleague who is also on the House Veterans' Affairs Committee, the Honorable Claude Harris, who is from 7th District of Alabama, for any comments that he might wish to make. Claude, thank you so much for being here this morning.

OPENING STATEMENT OF HON. CLAUDE HARRIS

Mr. HARRIS. Thank you, Mr. Chairman. As you know, this is my first visit to the Carl Vinson VA Medical Center, and I am very impressed with the staff and with the facilities.

As you mentioned earlier, the VA medical care delivery system is in dire financial straits. For instance, at the Tuscaloosa VA Hospital in my district, we would require additional funding of almost $2.5 million for 69 positions to bring the Tuscaloosa VA Medical Center up to community standards. These positions include physicians, registered nurses, licensed practical and vocational nurses, as well as therapists. In fiscal year 1988, inadequate funding reduced our drug and medical supplies and prosthetics inventory by $185,000 from the fiscal year 1987 level. We do not yet know how much the inventory will be reduced for fiscal year 1988.

Our survey of all VA hospitals reveal similar financial inadequacies at most hospitals. Yet, more and more veterans are seeking VA medical care as the World War II and Korean Conflict populations age, and we need solutions.

As you indicated earlier, one of the VA's cost-saving proposals is to close the surgical service here in Dublin as well as in other rural VA medical centers. As I understand it, no final decision has yet been made. However, it occurs to me that a decision to close the surgical service in rural VA hospitals could result in increased beneficiary travel payments as well as costs incurred in converting operating rooms and surgical beds to other uses.

I hope the testimony we receive this morning will point the way to solutions to the problems facing our VA health care delivery system.

Thank you, Mr. Chairman, for having this hearing, and I think it is at a time that certainly we do not have any time to waste.

Dr. ROWLAND. Thank you very much, Claude. I do appreciate that.

There is a member of Senator Nunn's staff here that I wish to recognize, Bob Bayer, and is Sherri Collier here for Senator Wyche Fowler? She was to come, and Congressman Charles Hatcher of the 2nd District was unable to join us today. I do have a letter from Senator Nunn here that I want to make a part of the record without objection.

[The letter appears on p. 99.]

Dr. ROWLAND. I would like to call now our first panel of witnesses, and let me say to the witnesses this morning that we are going to swear you in so that you can testify in any way that you so desire. Say what you feel like that needs to be said without any fear of recrimination, and we are going to limit testimony to 5 minutes. We have a good many people that are going to be testifying, and we have a little bell that we are going to ring here at 5 minutes. It will be loud enough for you to hear it there at the table.

I would like to call as the first witnesses on the first panel Mr. Donald Thompson, the director of the Southeastern Region, Department of Medicine and Surgery, Veterans' Administration; accompanying him will be Mr. William Edgar, the director of the hospital here at Dublin; and Mr. Glenn Alred, director of the VA Medical Center in Atlanta, Georgia; and Mr. Donald E. Burnette, director of the VA Medical Center in Augusta, Georgia. Gentlemen, if you would come to the witness table, we would appreciate it.

I will ask you if you will just stand for a moment and raise your right hand.

[Witnesses sworn en masse.]

Dr. ROWLAND. Please take your seats, Gentlemen. Thank you again for being here, Mr. Thompson. You may proceed as you so desire.

STATEMENT OF DONALD B. THOMPSON, DIRECTOR, SOUTHEASTERN REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION; WILLIAM O. EDGAR, DIRECTOR, CARL VINSON VA MEDICAL CENTER, DUBLIN, GA; GLENN ALRED, JR., DIRECTOR, VA MEDICAL CENTER, ATLANTA, GA; AND DONALD E. BURNETTE, DIRECTOR, VA MEDICAL CENTER, AUGUSTA, GA

STATEMENT OF DONALD B. THOMPSON

Mr. THOMPSON. Thank you, sir. Mr. Chairman, Congressman Harris, guests, it is my honor to be here today to represent the Veterans' Administration, and to discuss the health care needs of the veterans in the Carl Vinson VA Medical Center area as well as other areas throughout our Southeastern Region. I am pleased to have the opportunity to provide you with this overview and then to respond to any questions that you may have.

As director of the Southeastern Region, I have been asked to present my position on two issues of importance to veterans, not only in this area, but also the rest of our region.

The first issue I will discuss is the provision of rural health care for veterans in the Southeastern Region and in the service area of the Carl Vinson VAMC. My position is that VA facilities must provide care for veterans whose care is mandated. Actions that we have taken indicate our commitment to placing health care services where they are needed, be it rural or urban setting.

The Carl Vinson Medical Center is a fully operational primary and secondary care hospital, making appropriate tertiary referrals as needed and adequately providing for the health care needs of the veterans it serves. I feel that the facility has experienced no significant problems in delivering health care to its veteran population. The facility has received its share of recurring dollars made available to this region and will continue to do so provided it remains efficient and cost effective in operations while maintaining its level and quality of care.

Since 1983, the medical center has seen its recurring resources base increase by 38 percent, or $9 million, raising it from nearly $23 million in 1983 to $32 million in 1989. Its employment has also increased by 50 positions during this same period. As regional director, I have also funded two MEDIPP actions at Dublin just this past fiscal year which provided for an initial Psychiatric Bed Service capability and a Mental Hygiene Clinic. Recurring resources in the amount of $1,300,000 and 41 FTE were provided to the medical center for these initiatives. These monies constitute nearly 33 percent of the total recurring dollars made available to me for new program initiatives for all 21 medical centers in this region. In 1987, the medical center also received 7.4 FTE and $212,000 for another MEDIPP initiative to convert 30 medical beds to an Alcohol Treatment Unit to serve the area and other district needs. Since 1982, I have also provided $2,597,000 in recurring and nonrecurring regional operating funds to the medical center for other programs.

Now, I would like to focus on the subject that has raised so much anxiety in this particular community over the past few months regarding the planned closure of Surgical Service at the Carl Vinson

Medical Center. First I must state that there is no approved plan closure at this time.

The subject is being addressed by an ad hoc committee established within Medical District 9 to review the Surgical Service at Carl Vinson Medical Center and determine what level of Surgical Service should be provided at the facility, considering such issues as opportunities to regionalize services without compromise to quality. The Task Force's report has been sent to the Regionalization Technical Advisory Group for the District, but it has not yet been referred to the District Planning Board or to the District Executive Council. Both of these groups must make a final recommendation to me prior to my review.

This Task Force report, as part of the district planning process, must now withstand both district and regional reviews. If the district endorses the report and forwards it as a formal proposal, the Regional Planning Board will critically evaluate it before any action is recommended to me with regard to what would constitute a basic mission change.

My first concern, should the report come to me, would be the degree to which a recommendation to close the surgical unit is based upon an assessment of the quality of the services provided and the qualifications of the staff. I can say without hesitation that if it were determined to be of poor quality, I would close the unit, but this does not appear to be the case in this instance.

In considering this particular recommendation, if it comes to me, I would determine the effect any such closure would have on the veteran being served by the Carl Vinson facility. I would have to be assured that alternative sources of care are available and that the quality and the costs of these alternatives are appropriate. Further, I would require documentation on how affected employees would be accommodated and that they could be properly reassigned to other jobs. I would require an implementation plan to assure that transfers between medical centers were made at minimal inconvenience and discomfort to the patient. I would also require a formal assessment of the ability of the Carl Vinson VAMC to recruit qualified staff in other disciplines should the surgical services be eliminated from their mission. My personal opinion is that every facility that is operated as a hospital should have the capability to provide basic ambulatory and inpatient surgical care at the primary and the nonspecialized secondary level. Moving all veterans needing minor surgery to a tertiary care medical center is, to me, a very false economy. I reiterate that I have seen no formal recommendation from Medical District 9 to close the Surgical Service and therefore have made no decision on a mission change for the Carl Vinson VA Medical Center.

Mr. Chairman, I would like to add, however, that I fully support the continuation of the process of review and assessment in the Medical District MEDIPP process. They must have the opportunity to objectively look at all services in all medical centers and to recommend appropriate changes. We all recognize that these are difficult times financially, and the rising costs in health care present a challenge to all of us, and we must manage our resources with ever increasing efficiency and effectiveness.

That concludes my formal remarks.

[The prepared statement of Mr. Thompson appears on p. 37.]

Dr. ROWLAND. Thank you very much. I am going to ask Mr. Edgar, since he is the director of this hospital, if he has any comments that he would like to make?

Mr. EDGAR. Congressman Rowland, I would keep my comment very brief at this time. I would just really like to welcome you and the Subcommittee, our distinguished guests, on behalf of our patients and my staff. I would like to welcome all of you up to our medical center too.

Dr. ROWLAND. Thank you very much, Mr. Edgar.

Mr. Thompson, I am very pleased to hear you say that in your opinion every facility that is operated as a hospital should have the capability to provide basic ambulatory and inpatient surgical care at the primary and nonspecialized secondary level, and I want you to know I very strongly agree with that. We understand the process that must be gone through here, and that it has only just begun, but let me ask you this: In your opinion, why was the Dublin surgical review ad hoc task force appointed by the district director?

Mr. THOMPSON. As a matter of fact, the MEDIPP guidance that was issued nationwide, both by the Chief Medical Director and then supplemented by each of the regions and each of the districts, call for further MEDIPP reviews to look at the missions to determine that the best mix of services within a district are made available. We are trying to produce, with limited resources, a full continuum of care, and that includes everything from primary care all the way through secondary and tertiary care, teaching programs, nursing homes, domiciliaries, but we need to do it so that it functions as a regional unit or a district unit to make sure that we do not have unnecessary duplications or unnecessary problems.

One of the major issues that we are trying to address is the appropriateness of putting a facility at risk. In other words, we must know that a facility can recruit the physicians that it needs to carry out its mission, and I think, as you well know, it is quite difficult, given the earning capacity of some of the specialties, to put too much specialty emphasis in rural areas. We just cannot get physicians to go into those areas. So, it is essentially an attempt to balance the program within a given district so that we establish referral patterns and avoid unnecessary duplications. Also, it does make it more economical although the primary consideration is not costs saving.

Dr. ROWLAND. So, it is a combination of things that are being looked at. I guess—I heard the phrase appropriateness of resources that are available.

Mr. THOMPSON. Yes, sir.

Dr. ROWLAND. I have not heard anything about an inferior quality of care in the surgical service here, and I do not believe there has been anything pointed out in that respect.

Mr. Edgar, do you care to respond to that?

Mr. EDGAR. Congressman Rowland, to the best of my knowledge, there has never been any question about the quality of our surgical care here at Dublin.

Dr. ROWLAND. Mr. Harris?

Mr. HARRIS. Thank you, Mr. Chairman.

Mr. Thompson, let me ask you this. When veterans are living many miles from the hospital, how likely is it that the veteran will remain in the hospital longer than a veteran who lives very close to the hospital?

Mr. THOMPSON. I hope I heard that properly, Congressman Harris. You are asking me is it more likely that a veteran living distant from the hospital will stay in the hospital longer than——

Mr. HARRIS. Longer than one living closer.

Mr. THOMPSON. Only to the extent that that might involve difficulties in arranging transportation or follow-up care back in his community or the area in which he lives. We certainly try not to have a patient released from the hospital prior to establishing how his after care is going to be taken care of, but as far as the actual treatment of the condition for which he enters the hospital, the distance from the hospital itself is not a particular factor, but I think, as a generalized statement, you could probably establish that people living remote from hospitals do tend to stay a short time longer than people who live nearby simply because of the accommodations.

Mr. HARRIS. I think it is obvious, and of course Dr. Rowland touched on it, about the fact that the hospitals have been juggling the funds around, certainly in your region, I am sure, and I am not sure whether Tuscaloosa is in your region or not, but——

Mr. THOMPSON. Yes, sir. It is.

Mr. HARRIS [Continuing]. But as a member of the Committee—Of course, I have only been there two years—I certainly was not aware of that and the budget requests made did not indicate that, and my question to you, did you complain to Washington about the juggling of funds and that here we were spending money for day-to-day operations that were for other things?

Mr. THOMPSON. Yes, sir. I have made my position known probably almost to the point of overkill. This region is considered to be somewhat in a peculiar position in the VA because of the large growth in the veteran population, and the migration of veterans from other areas, and the difficulty we have had in having the funds follow those veterans into the region.

Let me just start with a figure that we have reasonably well fixed. Our projected short fall for this region alone in fiscal year 1989 is somewhere in the neighborhood of $80 million, give or take a few million. This is a result of, one, a continually increasing demand; an inability to garner new resources because any resources that our region gets necessarily takes from the total system. Congress has been very generous with the Veterans' Administration. We have always gotten more money than we've asked for, and of course, the Administration is always under pressures to hold costs down. Two, we have some very significant problems in terms of our total funding. We have robbed from other accounts to support a personal services or an employment level that is at some times difficult for us. We have taken equipment monies that are needed to keep us in a state of good repair and high technology for other uses. We have diverted maintenance repair monies to buy drugs and medications.

Our increased short fall this year is about $14 million, adding to our prior shortfall. You know, we look at our relative purchasing

power after we put our staff in place as an indication of our relative wealth, and we are about $12 million short in 1989 as opposed to 1988.

Does that clarify some of it?

Mr. HARRIS. Well, just speaking for myself, I know I was certainly shocked when I heard that we were talking about a $600 million shortfall; when I heard the Director of the Veterans' Administration telling us that, "These dollars are what we need," and no mention of it, and then you turn right around and we find out we are robbing Peter to pay Paul, and all our pockets are empty now.

If we are going to get our hat in the ring, we need to get it in there early when we are talking about the funds being allocated, and it is harder to get supplemental appropriation than it is to get it to start with.

Thank you, Mr. Chairman. That is all I have.

Dr. ROWLAND. Thank you. Let me ask a question to Mr. Alred and Mr. Burnett of Atlanta and Augusta. What kind of affect would the closing of this unit here at the Dublin Hospital have on your hospitals? Mr. Alred?

Mr. ALRED. Maybe Don could speak to this first because he is closer, and then I will follow up.

Dr. ROWLAND. Okay. That will be fine.

Mr. BURNETTE. We are not really sure. We have not actually studied and planned out—As part of the planning process, we will have to look at the effects that it would have on Augusta. In round figures, I think we did approximately 700 or 800 surgeries for Dublin last year, and I think Dublin accomplished in the neighborhood of 300 surgeries. How much this would affect us, I do not know.

As I mentioned yesterday, we are down 60 RN's out of a ceiling of 358. We have two wards closed, a medical ward and a surgical ward. We have 12 of our 30 intensive care units beds closed only because of the nursing shortage.

We may find out as the study progresses that we would not be able to take additional workload without the ability to recruit more nurses either with the bonus passage that we have talked about or any number of things.

Dr. ROWLAND. You have a tertiary hospital in Augusta.

Mr. BURNETTE. Yes, sir.

Dr. ROWLAND. And this is a primary secondary hospital. Here they do such things as TUR's, and hernias, and hemorrhoids, and things of that nature. Is it appropriate to do this type of surgery in a tertiary hospital if the hospital is already in a bind?

Mr. BURNETTE. That would probably come out in part of the planning process, but my professionals, Chief of Surgery, Chief of Medicine, and these kind of people, would have to make that determination. As a non-physician, I would not say yes or no.

Dr. ROWLAND. Mr. Alred?

Mr. ALRED. Congressman, we are probably a little bit further, as you well know, from Dublin, and the cases that come in to us will—Well, we never really have a problem on having surgical cases. We have got an abundance of them. We have probably—we have got the largest primary service area in Atlanta—in the Atlanta primary service area, about 412,000 out of the 660 some odd

thousands. So, we really never have a problem as far as surgical cases in Georgia, and the distance probably would play an impact on us, but we do receive at different times very critical cases because of our association and affiliation with the Emory University Medical School. So, that would probably be as effective as we could be with utilizing the very special activities and surgical procedures.

Dr. ROWLAND. You probably would not be able to contribute a great deal then.

Mr. ALRED. We contribute some, but not as much as probably Augusta does in the overall.

Dr. ROWLAND. Let me ask you something in another area about more flexibility in reference to funds that you have. There are some accounts that you cannot transfer funds out of for use. Would you, as directors, all of you, be more pleased to be able to transfer funds from those accounts that you cannot transfer funds from at this time in order to have more FTE's, more equipment where equipment is becoming now a state of art, things of that nature?

Mr. BURNETTE. Don Burnette from Augusta. Yes, sir. We would also like to see the 400 or 500 ceilings removed, all the caps, corridors, so we could operate the hospital. I think we could do a much better job if all the restrictions were removed.

Mr. ALRED. I have, Congressman, been an advocate of this flexibility for a number of years, and just recently the VA has been doing some testing in five facilities around the VA system to do some of this, releasing some of the controls in these areas. I have had a great deal of involvement as far as the local community within the Federal Executive Board in asking for this type of efficiency-type activity. I think we could do a good job with it.

Mr. EDGAR. Congressman, I think the key to running a successful operation as far as the health care facility is flexibility. I would certainly like to have the opportunity to have maximum flexibility to the resources provided to our hospital. I can think of instances when I have had surpluses in one account and deficits—I should not say deficits—short falls—short fall in other accounts, and because of the constraints, I could not move those monies from one account to another. So, certainly I think it would improve our ability to manage our facilities if we could get more flexibility with our resources.

Mr. THOMPSON. As the regional director as opposed to hospital director, let me say that I feel that the system would work best if, when it came time to building our hospital budgets, we went to the hospital and said, "You tell us what level of workload you need to meet, and then tell us within the dollars that are made available, on whatever mechanism used to apportion those dollars, how many FTE, how many different types of programs, how much money you are going to spend for various things. You tell us, and then that will be what your plan is."

The way it is now, we give them a personal services floor which means that dollars must be put into their budget at that level. They may not this year be supplemented, and that means it presumes that that hospital is going to have exactly the same mix of employees every day of the year, and the real world of hospitals does not work that way. Our patient load fluctuates month to month. Our demand for various specialties fluctuates month to

month, and we need the flexibility, I think, in our hospitals to be able to deal with that in a much more rational basis than we are now, and that would give the hospital director the opportunity to accumulate funds in one area and reassign them to other places where they are needed. It would be much more effective that way.

Dr. ROWLAND. Thank you. I have one other question that I want to ask you, Mr. Thompson. Is a mission change being considered at Dublin?

Mr. THOMPSON. No, sir; not by my office. And the end decision would be mine.

Dr. ROWLAND. Thank you very much. I want to thank all of you for being here this morning. We do appreciate so very much your participation in this hearing. Thank you.

I will ask the next panel if they will please come forward, Dr. James Allison, chairman of the Dublin Surgical Review Team and chief of staff at the VA Medical Center, Charleston, S.C.; and Dr. Wendell Musser, chairman, Medical District Planning Board, and chief of staff at the VA Medical Center in Atlanta; Mr. Thomas Cappello, chairman of the Regionalization Committee, Southeastern Region, and associate director of the VA Medical Center at Charleston, South Carolina.

Gentlemen, if you would come forward. And Mr. Harold Duncan, former director of Carl Vinson VA Medical Center here in Dublin.

Harold, I did not overlook you there.

I would ask you all to just stand for a moment and raise your right hand.

[Witnesses sworn en masse.]

Dr. ROWLAND. Please be seated, Gentlemen. Dr. Allison, if you will proceed first in any manner that you so desire, and if all of you would try to hold it to 5 minutes, then—By the way, all of the testimony that you have will be submitted for the record without objection.

STATEMENT OF DR. JOHN ALLISON, CHAIRMAN, DUBLIN SURGICAL REVIEW TEAM AND CHIEF OF SURGERY, VA MEDICAL CENTER, CHARLESTON, SC; DR. WENDELL MUSSER, CHAIRMAN, MEDICAL DISTRICT PLANNING BOARD AND CHIEF OF STAFF, VA MEDICAL CENTER, ATLANTA, GA; THOMAS CAPPELLO, CHAIRMAN, REGIONALIZATION COMMITTEE, SOUTHEASTERN REGION, AND ASSOCIATE DIRECTOR, VA MEDICAL CENTER, CHARLESTON, SC; AND HAROLD O. DUNCAN, FORMER DIRECTOR, CARL VINSON VA MEDICAL CENTER, DUBLIN, GA

STATEMENT OF DR. JOHN ALLISON

Dr. ALLISON. Congressman Rowland, Congressman Harris, I thank you for the opportunity for being here. I think this is a very important opportunity. I must confess that I was expecting to face a barrage of questions rather than have the opportunity to make a statement, but I welcome that opportunity. I do not have——

Dr. ROWLAND. Questions will come.

[Laughter.]

Dr. ALLISON. I am sure they will, sir. I am very gratified that this activity that we are participating in today is going on because we are in difficulty in the health care delivery system in the VA.

I sit here as an administrator or manager at the District level, but I am also a surgeon and a chief of a surgical service and, as such, I am an advocate of the patient. You are lucky in wearing two stripes, inasmuch as being a physician yourself you are an advocate of the patient too, but in your position in the House of Representatives, you are also a political representative of our population that we serve. I think that what we are doing sitting here today is saying the same thing in the interests of providing appropriate levels of health care to our veteran population.

Much has been said already about the resource restrictions and the impact that it has on the quality of care. I attended the joint meeting of the Association of American Medical Colleges and top VA management in Chicago in the middle of November, and I was very privileged to be able to address two bodies. One was the Society of Surgical Chairmen, a very elite body of the Chairmen of all surgical services at academic health centers throughout the country. I also sat on a panel at the joint AAMC/VA meeting and had an opportunity to address with my friends and my colleagues in the provision of health care the impact of resource restrictions on the quality of care.

I regard quality of care, starting at the bottom line, the first step in quality care is that one should provide reasonable access to appropriate levels of care in all areas and, from then on, we get into the staffing levels of hospitals and the equipment needs and so forth. We have identified, and I do not think anyone would deny this particularly after the House Hearings in early September, that we do face a short fall in the Veterans' Administration's ability to continue providing, in an escalating cost era the level of quality with the same resources that we had the year before, the year before, and so forth without substantial increases in resources.

One thing has to give. We either have to get substantially more resources to continue the level of quality, or if we are facing short falls, it is going to impact on quality. We are going to start starving quality. We are going to start cannibalizing quality in one area to provide quality in another, and that, I think, is part of the major issue.

If I may go from that to the issue here in Dublin, which regards the surgical service. As chief of the Surgical Service of the Charleston VA in South Carolina, I am automatically on the District Surgical Service Committee and I am presently serving a two year term as chairman of that particular committee.

The Surgical Service District Committee is charged with looking at and evaluating issues in the planning process with regard to the provision of quality surgical care at appropriate levels within the district. We look at a number of issues and the Dublin Surgical Service is one of those issues, one of many issues that we have looked at, among many others.

I received, as chairman of that committee, a letter from the chairman of the Regionalization TAG or Technical Advisory Group dated March 28th requesting that we evaluate the Dublin Surgical Service surgical program with the following variables to be considered: the impact on quality of care; the impact on access to care for the veterans; the impact on the resource allocation; the impact on staffing; the impact on anethesia; the case load absorbtion impact;

emergency and/or backup services for the needs and availability within the community of Dublin; the future considerations, for example, potential for DOD sharing and sharing agreements. That last item was not really an issue, and I discussed this with the Chairman. We did not really get into that.

In response to that, considering some of the information at hand, I felt, in a conference call with the members of my committee, that it would be in the interest of the district and in the interest of the Dublin VAMC for there to be a site visit so that we could be here to talk with people, interview staff, look at the facility, be able to sift through the necessary data, to come to a more informed conclusion, and that we did. We met back in June, I believe it was, June 24th—June 23rd and 24th, here in Dublin at the VAMC and interviewed several people.

On the task force were not only myself, being a surgeon. There was a chief of surgery from a VAMC not within this district or within this region. There was a surgeon from Atlanta who is in the ambulatory care program there. There was another physician who is the associate chief of staff for education, I believe, in Augusta who is also a qualified gastroenterologist. With us we had some administrative support and evaluated as much information as was provided to us.

We came up with a conclusion that, given certain provisos, it would be feasible—and I emphasize the word feasible—it would be feasible to not have a fully operational bed service for surgical services. Those provisos were necessary to shore up any holes and prevent any cracks through which anyone could slip in terms of provision of quality of care. The committee was adamant—or the review team was adamant that were those provisos not met, the Dublin Surgical Service should continue and could not be closed.

Thank you for the opportunity to address this body.

Dr. ROWLAND. Thank you very much, Dr. Allison.

Dr. Musser?

STATEMENT OF DR. WENDELL MUSSER

Dr. MUSSER. Thank you, Mr. Chairman. Mr. Harris, it is good to see you again. Your sympathetic responses on the 7th of September made that trying day a little more satisfying.

I want to summarize some comments that I put into the record for the House on the 7th of September and into the record for the Senate on the 9th of September of this year. This is not a formal statement. These are some informal comments that have been derived from that testimony.

I would like to address the FY 1989 budget short fall which has been a cumulative thing beginning many years back, probably in the middle of the 1970's, and it appears from the economies of this country that these budget short falls will continue.

The VA health care system faces the same rigors of present day economics as does all segments of our Federal budget. We not only face the general conundrums of the national economic picture, but we are attempting to determine where we stand in the national health care picture. We should not delude ourselves into thinking

that we are immune to the competitiveness that permeates the struggle for health care dollars.

We, of course, are dedicated to a defined segment of that national health care scene. Our quest for solutions is compounded by the complexity and multiplicity of our mission as defined by statutes and tradition. We must and will care for the eligible veterans under the constraints of the resources supplied to us. We will continue our contribution to the national pool of health manpower. We will turn back the frontiers of medical science in those areas relevant to our beneficiaries, and lastly, we will support the defense posture of this country as the statutes dictate to us.

Over the years, those much needed entitlement statutes have increased the need and expectations for care. Each budget year we have fallen behind in resources; some years greater than others. The time of accountability is upon us. This FY 1989 budget year is a crisis year of contemplation and re-assessment. FY 1988 survival has forced us to redistribute resources, to rearrange care packages, to delay maintenance of our facilities, to eliminate purchase of much needed equipment, and to invariably come to the ethical brink of proposing actions that may not be in the best interests of the patients we serve. The proposed FY 1989 budget forces us to reassess what we are really doing and what we should be doing. Under the present proposal, we cannot meet the expectations of the legislation and the expectations of our patients.

It is time to re-examine carefully and in an apolitical fashion the distribution of the present resources. Are we responding properly to the health care of high priority patients? Is there a need to introduce and re-emphasize the resource distribution methods that consider access parity as we are presently doing and maybe fine tune it even more? Is it time to take full account of our backlogs in maintenance and repair equipment and staffing deficiency?

I will not repeat some of the things or informal statements I have made at other times, but we are showing staffing deficiency, closed beds, loss of shelf inventories, and a real crisis of maintenance and repair, and a pressing need for equipment.

You must understand that we will, in our commitment, our undying commitment to this organization—And we truly mean that—we will form and shape the care packages within the constraints of the available resources because that is our job. Our overriding concern will be to deliver quality of care and to comply with our legal, moral, and ethical imperatives as we deliver that care. We are dedicated to the patients we serve and their families. We are proud of the large army of dedicated and committed health care workers as they work to deliver that care, and may they always, with the help of God, be the true advocate of the veteran patient.

Dr. ROWLAND. Thank you, Dr. Musser.

Mr. Cappello?

STATEMENT OF THOMAS CAPPELLO

Mr. CAPPELLO. Let me thank you, Congressman Rowland and Congressman Harris, for giving us the opportunity to speak here today. I, like Dr. Allison, was not prepared to make a statement, but I would like to take this opportunity to address two issues very

briefly. These are the VA budget picture and how it affects particular hospitals and also to recap for you the activities of the Regionalization Committee as it affects Medical District 9 and the Dublin Surgical Service.

As the associate director at the VA Medical Center in Charleston, SC, and the chief operating officer who is charged with the responsibility for administering the budget, I can say that I think it has been remarkable how we have been able to maintain full employment in a decremental budget situation. I agree wholeheartedly with Mr. Thompson when he says that we need the flexibility to be able to move funds within accounts to meet our workload, pay for supplies and maintain full employment. For example, at the VAMC in Charleston, over the last three years our pharmacy budget has escalated from $2.3 million in FY 1986 to $3.5 million in FY 1988, and we have been able to meet this challenge without significant additional resources by being able to move funds around the different supply accounts. However, this year we have a personal services floor, and although we were prepared to move funds between accounts to meet our full employment and workload because of this personal services floor, the VAMC in Charleston will probably, be reducing our FTE complement by 16 people, unless there is some relief.

On the subject of the Regionalization Committee, I would like recap our activities for you and try to bring into perspective where we are today with the issue of the surgical program in Dublin.

On October 22, 1987, I received a memo appointing me as chairman of the Regionalization Committee and a charge letter indicating what this committee should review. This charge came from the instructions in the FY 1987 and 1988 MEDIPP Guidance—the charge letter indicated that we were to look at various services within the district with the opportunity, where possible, to consolidate and eliminate unnecessary services. Also in the charge letter there were several areas that were outlined that we ought to look at, and that is the regionalization of surgical specialties, cardiac surgery referrals, radiation therapy, and pharmacy services.

At our first meeting, we addressed all four of these topics. We made recommendations to the District Planning Board concerning how cardiac surgery referrals should take place in our district. We indicated that we would study the consolidation of surgical services here at Dublin. We outlined a study for looking at the regionalization of pharmacy services whereby we would be creating efficiencies by possibly filling outpatient pharmacy prescriptions from a central point, and those were basically the three areas.

The reason the Dublin Surgical Service was chosen as a study area was that in the MEDIPP Guidance it asked us to look at services which had a declining workload over the past three years and, in a data cut, the Dublin Surgical Service did, indeed, have a declining workload.

As we looked at the data for all the surgeries at Dublin, we had both medical and administrative representation on our committee. It appeared that many of the cases that were being done at Dublin could be done elsewhere. Not being able to fully study this, we had asked the Surgical Committee of the District to look at the Dublin Surgical Program. They looked at the data, indicated that it would

be best if an on-site study was done, and that is when the district director assigned an ad hoc task group to study it. That group conducted the study and provided information to the Regionalization Group.

And I will get to where we are right now. We have the report of the Ad Hoc Task Force and the response of the Dublin VA Medical Center. In our last meeting, the Regionalization Committee reiterated what we felt were several provisos that would be necessary in order to effect a consolidation of the Dublin Surgical Service, and we are in the process of studying and completing our study. We have yet to get a formal statement and meeting with the local hospital Administrator at the Fairview Park Hospital. In that meting, we will attempt to clarify that insitution's ability to handle emergency surgeries. We have asked also that the chiefs of medical services within the district and the chiefs of psychiatry services within the district give us a statement concerning the impact of this consolidation on their respective services, and at this point we are awaiting those responses. Once we have them, we will be ready to make a formal recommendation to the District Planning Board considering the consolidation.

Dr. ROWLAND. Thank you, Mr. Cappello.

Mr. Duncan?

STATEMENT OF HAROLD O. DUNCAN

Mr. DUNCAN. Mr. Chairman and other distinguished members of the Committee, I want to express my appreciation to this committee for the privilege of testifying at this most significant event in the long and illustrious history of this hospital.

I am no longer employed by the Veterans' Administration so I now speak for the middle Georgia community, but with the perspective of a former director of this medical center and a former medical district director of this Medical District, and I speak in strong support of this hospital and its surgical service.

It has been recommended that the Dublin Inpatient Surgical Program be abolished and that alternative resources and facilities be provided without detriment to the quality of care, without increasing costs, or without diminishing access to patient care in the Dublin primary service area. It is the thrust of my testimony that within these parameters, this is not possible.

Here and now we have a small but effective surgical service providing quality general surgical care with a high degree of patient satisfaction at a relatively low cost.

To substitute for this caring service, it is proposed to retain one surgeon on duty with no major operating suite. He would interview prospective patients here in Dublin, contract out some of them to the local HCA Hospital, and dispatch others by ambulance along 100 miles of two-lane State highways accommodating logging trucks, mobile homes, and frequently heavy traffic, and farm equipment, and supplies through several small towns with no bypasses to the Augusta VA Medical Center.

An attempt would be made to admit surgical cases immediately, but non-emergency cases would be admitted within priorities established by that hospital. This practice would present several prob-

lems. The first and perhaps most traumatic is that the Administrator of the local private hospital has stated categorically and in writing that he will not now or in the foreseeable future be available to provide alternative beds for our surgical patients, and beyond this there are only three general surgeons in Dublin, and two of them have responded that their practice is full and they would not be available for contractual services to outpatients. The third physician will offer only limited availability. And in short and concerning accessibility to alternative surgical service in Dublin, there is absolutely none whatever.

One of the factors involved in the outpatient satisfactory level—satisfaction level in Dublin is its position near the center of the primary service area and with ready access to patients and their families for support. However, this is a rural area, and we have patients and families who have never been to Augusta and never will. There would be a problem in supplying funds and transportation including staff support for emergency cases, transportation expense including staff overtime while on safari to Augusta——

[Laughter.]

Mr. DUNCAN [Continuing]. And a relatively high percentage of broken appointments. I submit all of this represents a diminished level of surgical patient care.

But perhaps the impact of the proposal upon professional services other than surgical is even more traumatic. To say that the professional staff here is concerned is an understatement. Their morale is at an all-time low, and one physician has already resigned.

Partly in response to these concerns, the chief of medical service from the five VA hospitals in this medical district met to review the proposals and to evaluate its impact. They considered all the materials given to them by the various committees, and they contacted the 12 hospitals who are now operating under this procedure which is recommended for Dublin. Of the 12 hospitals contacted, 11 expressed degrees of disenchantment ranging from displeasure to indignation. Excerpts from all these responses are contained in the formal paper, and I wish I had time to mention them now, but I must press forward.

But after studying all these materials, the five chiefs of medical service in this medical district issued a detailed consensus report of their finding clearly supporting the retention of Surgical Service in Dublin. This is an excerpt. "It is our belief that the removal of inpatient surgical capability in Dublin would negatively impact upon the quality of medical care and impair their ability to attract the physicians necessary to run an acute medical service," and again, "We believe that it is our professional duty to state the consequences as we see them and others have experienced."

A third criteria was cost, including the cost of contracting out, and we have a cost comparison which indicates this procedure would not be cost effective is contained in our formal statement, but since it is not—but since alternative facilities are not available to Dublin, this becomes irrelevant at this time. We then submit that the abolition of surgical services is clearly not working when it has been attempted and would not work here, based on its own

merit. It is therefore our concern that it may not be proposed as an element of a longer range plan of much broader consequences.

In the minutes and in discussing the facility mission of this medical center, this statement was made, "If it is an intent for the mission to change to one of long term chronic care only, there is no need to maintain any surgical activity."

The loss of surgical service would initiate a clear path of regression. Next would be loss of acute medical service, inability to recruit quality internists for only a chronic care facility, and the dominos would continue to roll.

Our position is that this is undesirable, unnecessary, and contra indicated. Our appeal is to Central Office to plug this hole in the dike and set us once again about our business of caring for our patients.

We express our appreciation to this committee for the opportunity to be heard and for your unfailing support which is needed now more than ever before during the critical days ahead.

[The prepared statement of Mr. Duncan appears on p. 48.]

Dr. ROWLAND. Thank you very much. With that very eloquent statement, Dr. Allison, let me ask you this, if I may. Are there any members of the panel from the hospital of the rural areas that do primary and secondary?

Dr. ALLISON. The chief of surgical service, Dr. David McAffee, who is on the panel is from Fayetteville, AR, which is a small rural VA, which has its main relationship with Little Rock. They send a lot of their major surgical cases down there.

Dr. ROWLAND. Is that hospital being considered for closure or changing its admission and other——

Dr. ALLISON. I am unaware of any.

Dr. ROWLAND. There has been no recommendation as far as that hospital is concerned?

Dr. ALLISON. Not to my knowledge.

Dr. ROWLAND. You mentioned cannibalizing the quality in the statement that you made, and I think Mr. Duncan pointed out that once you started dismantling services or removing one service, cannibalizing that service may well impact adversely on other services in the hospital, the medical service, for example. Can you address that, or speak to that point?

Dr. ALLISON. Yes. I think that potential exists. I think anyone would deny that the possibility exists. However, I will remind you, Mr. Chairman, that we had on our task force a gastroenterologist, from Augusta, who was looking at it from the perspective of the internist's point of view, as well—as we all did, and the main track of our thinking was, if these surgical services were not available at the Dublin VAMC but were available through another channel, would that have an impact? And we spent a lot of time discussing that particular issue. We were aware of the need to maintain quality in the other areas, particularly the other major med services here, medicine, psychiatry, the domiciliary unit and so forth, and we recognized—in fact, I think my final statement suggested, or put—not suggested, but said that it may have an impact on mission, and it may have an impact on the ability to recruit and retain. I did, however, also put there the statement that with good leadership, strong leadership and a positive attitude it could prob-

ably be accomplished, and by that I mean, if adequate, reasonable access to surgical care could be provided to the veteran population in Dublin's PSA, who are currently using Dublin as their health resource center, could still gain reasonable access to appropriate levels of surgical care and with a positive attitude, the impact of quality and care of the remaining bed services and the rest of the functions of the hospital, there would be very little change.

Dr. ROWLAND. Mr. Harris?

Mr. HARRIS. Mr. Chairman, I do not believe I have any questions. I would just say "amen" to what Mr. Duncan said.

Dr. ROWLAND. I asked Mr. Thompson earlier if there was any contemplation of changing the mission of this hospital her and he said not in the perspective of his office at this point. Do you think that closing the surgical service here would lead to a change of the mission of this hospital?

Dr. ALLISON. If I may respond, Mr. Chairman, getting back to one of my earlier statements that the task force came out with the conclusion in their recommendations of looking at the feasibility of closing the surgical services at the Dublin VAMC. There were certain provisos that had to be fulfilled if there was going to be any attempt to close the surgical service as it exists now at the Dublin VAMC. I think it is stated, or if not stated in so many words, implicit and tacit in that document that if these provisos could not be met the surgical service should not be closed. I think there may be an impact. We recognize that. There may be an impact on the mission of the Dublin VAMC. I think there is going to be an impact on the mission of the VA throughout the country under the current situation. It was not within the purview of our task force to make final decisions, to make decisions on the mission of the Dublin VAMC. We were there to evaluate a feasibility question, sir.

Dr. ROWLAND. You said that if certain provisos could not be met. I have heard from Mr. Duncan that—I believe there were two surgeons in this city who had—there were three surgeons, two of them already had a full patient contingency and that the hospital here, the private hospital here is not interested in taking on a contract basis, veterans here. Were you all aware of that? Did you talk with the people at HCH? Did you talk with any of the surgeons here at Dublin before you issued this recommendation about whether or not that proviso could be met?

Dr. ALLISON. I talked with two surgeons. One surgeon, Dr. Tanner, indicated he would not be interested in taking on additional workload, and in fact was beginning to come down on his workload. We also spoke to a younger surgeon in town who expressed no difficulty with the concept of dealing with what we had termed a catastrophic emergency. Emergencies of being within the operating room within an hour or two at the Medical Community Hospital.

Dr. ROWLAND. And did you talk with the hospital administrator at HCH?

Dr. ALLISON. I personally did not talk with the hospital administration, but there were members of our task force who did.

Dr. ROWLAND. And what was the response that they got to your knowledge?

Dr. ALLISON. My impression was that if satisfactory contracts could be worked out with the various services and with the hospital that would certainly be a consideration.

Dr. ROWLAND. I guess we have some conflicting information here then that would need to be resolved. If that proviso could not be fulfilled, certainly it would make you want to consider a second look at the recommendation that you have made.

Dr. ALLISON. If that proviso could not be met, I would not need a second look, sir.

Dr. ROWLAND. Would you explain that?

Dr. ALLISON. If that proviso to be able to provide catastrophic surgical care within the community of Dublin could not be met is tacit in the recommendation of the hospital that the surgical service should not be changed.

Dr. ROWLAND. Okay. Thank you gentlemen very much. I do appreciate you giving testimony here this morning.

The next panel that I would like to call is Dr. Dan Elrod, who is chief of staff here, and Mrs. Buchanan, who is chief of the nursing service, accompanied by the chief of medical services.

[Whereupon, the panel was sworn en masse.]

Dr. Elrod, proceed as you desire.

STATEMENT OF DR. DAN ELROD, CHIEF OF STAFF, JANICE BUCHANAN, CHIEF OF NURSING, DR. A.C. PRADHAN, CHIEF OF MEDICAL SERVICES, AND WILLIAM O. EDGAR, DIRECTOR, VA MEDICAL CENTER DUBLIN, GA

STATEMENT OF DR. DAN ELROD

Dr. ELROD. Thank you Congressman Rowland, Congressman Harris, for the opportunity to address this subcommittee here.

I come here with only one issue, and that is the issue of the closure of our in-house surgical unit.

We have submitted to the District Regionalization Committee our response to the report prepared by that ad hoc task force. I would like to summarize our position as best I can.

We feel that the task force recommendations are not in the best interests of our veterans or our staff at the Carl Vinson VA Medical Center. Our objective is to provide quality care to our veterans. The potential compromises in quality and care in the in-house surgery as non-operational will effect us in many ways. There is no hospital readily available to provide support services for the care of our veterans that are in the rural area. There is only one hospital that has been alluded to and that is Hospital Corporation of America facility here. This hospital does have a surgical service, but the management, and I can assure you, I have been told, and it is alluded to in these documents, will not handle our cases there.

There are now four surgeons in our area. A young surgeon came in approximately a month ago. I had talked with him too, sir. Only one surgeon made his statement to me that he would be interested only to perform surgery in a catastrophic emergency when it does not interfere with his own caseload.

It is very difficult for me to concede that this hospital with its limited resources could really become instrumental in providing

surgical services for our 110,000 veterans in a 52-county primary service area.

The task force stated that a local surgical capability must be available. Well, that availability is not present. The task force also suggested that Augusta may be an acceptable alternative. I think Mr. Duncan alluded to that quite well, and I will not go into my prepared statements any further.

We do obtain fine results through our treating of patients here on our surgery unit. We feel that the loss of our surgical unit would also affect our acute medical ward because our surgeons provide surgical assessments and this is used to work out more beneficial treatment plans that we have, and without this surgical presence, the treatment plans would have to be modified. We feel the loss of surgery inpatient care would also impact on our ability to accrue certified physicians who have multiple expertise.

Dublin is not affiliated with a major medical school and does not have a great wealth of medical resources readily available as some other VA hospital in our district do. Dublin has no affiliation. Lack of public transportation and large geographic distributions of our patients must be considered. This hospital always attempts to stay within its capability, and we are not meeting here today to ask for increased surgical capabilities. We operate as a referral facility and we send many to Augusta. The surgery we do in Dublin is well within our capability.

The cost associated with maintaining the surgical capabilities that will meet the current established surgical workload can be provided at no additional costs, if you consider what has to be involved in beneficial travel pay to transport these patients otherwise.

To implement the task force's recommendation, Dublin will have to have a major operating room. If we do not have these operating rooms, which we already have in place, they will be standing idle, and our equipment will waste away.

There is also an assumption that quality of care will not suffer, but yet, from what I have found out professionally and historically, I feel this is wrong. It will be affected.

I would like to ask every decisionmaker to please remember that the local administration of the hospital in Dublin is not available for surgical care, and the local surgeons are not interested in providing veteran care, and for the increase travel and wages to provide quality care would be compromised to our benefit. Thank you, sir.

Dr. ROWLAND. Thank you, Dr. Elrod. You answered the question that I was going to ask you about the impact of closing this unit would have on the recruitment of positions here, and I think you have said it would very adversely impact on that.

[The prepared statement of Dr. Elrod appears on p. 53.]

Dr. ELROD. We have already been impacted on that, sir. We had a radiologist who got wind that our surgical unit was being considered to be closed and transferred to another facility.

Dr. ROWLAND. So just the perception has already caused some difficulty.

Dr. ELROD. Yes, sir.

Dr. ROWLAND. Dr. Pradhan, I believe you are shaking your head too. Mrs. Buchanan, what would be the impact on the quality of care from the standpoint of the nurses here if the surgical unit would be closed?

STATEMENT OF JANICE BUCHANAN

Mrs. BUCHANAN. I would like to respond that, first of all, it is well documented that we are providing excellent quality of care here at our facility. I feel the quality of care of is intertwined with two things. First of all, the quality of care that is given and the accessibility of that care. We have a very qualified staff in the operating room. It is among our most qualified. Our supervisor in the operating room is prepared at the Master's level, and she formally was the supervisor of the Medical Center at Central Georgia. So we feel confident in our quality of care. The very fact that we would have to remove the veteran, have an interruption in his care, fragmented, would certainly compromise the quality of care.

[The prepared statement of Mrs. Buchanan appears on p. 59.]

Dr. ROWLAND. Thank you very much. Any additional comment any of you would like to make?

STATEMENT OF DR. A.C. PRADHAN

Dr. PRADHAN. I would like to thank the committee for this opportunity.

As you know on June 23, 1988, a medical district surgical ad hoc task force met and recommended that our inpatient surgical center be closed.

The effect of this plan on our patient care would be tragic. Let me state categorically that all medical staff physicians and dentists alike, feel it would adversely affect quality of care, suppress medical demand and unfortunately some seriously ill patients could die without receiving proper care. Let me state that out the outset that our jobs are not at stake, but what is at stake is the quality of care.

We have reviewed the discussion in the Regionalization Committee Minutes of August 30, 1988. Minutes state review team recommendations will be accomplished with following conditions. The first requirement is a formal agreement between Carl Vinson VAMC and Augusta VAMC. We all know many difficulties we experience with speciality care. You can ask any of the staff physicians.

Also consider this hardship, extra 200-mile travel for a weak and feeble patient.

Task Force defines a catastrophic emergency as one requiring surgery within 1 to 2 hours, while they differentiate urgent care as the one requiring surgery in 4 to 6 hours, while there is no mention of what happens to your patient between 2 to 4 hours. No one has such crystal ball vision and this would never work in reality.

The second requirement is a formal agreement between Fairview Hospital and appropriate community services. This is not practical as stated by Fairview Administrator, and we have documentation on this.

Next is the formal agreement between one local surgeon and the Carl Vinson VA Medical Center. This is ridiculous because we

know that we have 110,000 veterans in our service area. Our surgery performed 2,473 cases and responded to 7,718 consultations with at least 800 emergent nature consultations. Please remember that two community surgeons have stated they are not interested because of their workload. The third surgeon has stated that his private patients would be his priority.

The third requirement is presence of a viable dialysis program. All nephrologists agree that loss of surgery would adversely affect our ability to provide acute dialysis services.

Next requirement is there would be no significant detrimental effect on acute medicine.

We have shown very clearly that loss of in-house surgery will adversely affect quality of care. This has been the experience and opinion of chiefs of medical service where surgery has been closed. This is also the expressed opinion of all the chiefs of medical services in our district. It clearly states removal of inhouse surgical capability in Dublin because of inadequate surgical back-up would negatively impact on quality of medical care and impair the ability to attract the physicians necessary to run an acute medical service. It further states that the absence of inhouse surgery capability seems to especially limit requirement of subspecialist whose invasive procedures require surgical back-up.

We know by year 2000, 2 out of 3 males over the age of 65 years will be veterans. With aging we face many problems including the urological problems. We are fortunate enough to be able to provide these essential services with a board certified urologist. Remember that no competent urologist, including ours will stay on the staff performing only outpatient urology.

Experiment of outpatient surgery will not succeed due to our rural setting. We will not be able to retain a well-qualified surgeon urologist.

Dr. ROWLAND. Dr. Pradhan, we are very short of time. Your entire statement will be made a part of the record. If you could just summarize at this point.

Dr. PRADHAN. Okay, sir. Just in short I would like to state the last one and that is I had the opportunity to discuss with many chiefs of medical service who are treating our rural population, and we all hope erosion of medical care for our veterans in rural communities will not be continued.

We take pride in our mission and provide quality care with cost effective manners. That is why I urge you, sir, to help us retain quality of care for our veterans in rural populations. Thank you so much.

[The prepared statement of Dr. Pradhan appears on p. 63.]

Dr. ROWLAND. Mr. Edgar, do you have a comment?

STATEMENT OF WILLIAM O. EDGAR

Mr. EDGAR. Congressman Rowland, I would like to make some additional comments. I did have a prepared statement, but I did not offer that at the very beginning, and I would like to ask your indulgence and do that at this time, and I will keep it as brief as I can.

Dr. ROWLAND. If you could just summarize it, we would be very grateful, and we will make it part of the record.

Mr. EDGAR. Okay. I would like to re-emphasize that it is in the initial stages, our recommendation to close our inpatient surgery. I want to emphasize that it is in the initial stages of what we call the Medical District Initiated Program Planning Process. It is a lengthy process. It is a very thorough process. It passes through an awful lot of levels of review before a final decision is made. I think it is important that we point out that these reviews are important to the VA planning process, and it is important for everybody to know that the recommendations presented as a result of these reviews must withstand both district and regional planning scrutiny.

Where are we? We are at the medical district planning process now. It has been stated that we have a task force recommendation. We have had our on-sight review. We would like to emphasize on August 10th we provided a very lengthy response to that recommendation and that is in the hands of the regionalization task force at this time.

Very simply stated, let me say that our response to that task force recommendation, thanked them for their effort and it disagreed with the recommendation, and our reasons for disagreement centered around the issues of quality of care, accessibility of care from the patient's viewpoint, cost issues associated with recruitment problems, which we have discussed this morning, and the lack of ability in the community to provide surgical back-up support.

I am hopeful that from the information that we have provided in our formal response that they will come to the conclusion that the inpatient surgical program should remain at our medical center. We feel that it is in the best interest of the veterans in our PSA and the medical district that inpatient surgery remain at our hospital. It is my firm opinion that we should remain a general medical and surgical facility that provides both acute services and long term care to our veterans. I think our minimal surgical presence as presently configured, compliments what I think is an excellent acute care medical service and a developing psychiatric service. I might add, this is the second full review our surgical service has had in the last five years, and would like to call to your attention that the last review that was done in 1983 not only recommended that our complete program be retained. It also recommended that we increase it to 40 beds. So that was a quite different recommendation.

In my opinion our hospital here at Dublin is what the 110,000 veterans in our PSA in our 52 county primary service area require. We are a general medicine and surgical hospital. My opinion is we should remain as such. We have a very small surgical service. There are only 31 beds. There is no doubt in my mind it provides quality medical care and a very high degree of satisfaction to our veterans. We do good general surgery while referring the more complicated cases to our tertiary care sister hospitals in this district after we perform the proper evaluations and pre-operative workups. I think we are very good at what we do in our service, and I think we do it in a cost-effective manner.

I have stated before there has never been any question about the quality of care of our surgical service. I expect there never will be. We are different. We are a VA Medical Center in a rural setting. We are the only VA Medical Center in the rural setting in this district. I would like to call your attention to the fact that we are 100 miles from Augusta. We are 130 miles from Atlanta, 171 miles from Columbia and we are 206 miles from Charleston. So we are quite a distance from our sister hospitals. In terms of geographical size, we have got the largest area in the district and most of this area is in a predominantly rural setting and there is already a problem for a number of our veterans regarding accessibility of care. A lot of our veterans live a long distance from our hospital. If we had a requirement to provide that inpatient surgery care at Augusta as opposed to Dublin that would exacerbate a very important problem of accessibility of care now.

This past year we have seen an increase in our patients coming from the southern part of our primary service area. It doubled in the last year, as a matter of fact, and we have about 25 percent of our patients in that area who would have to travel another 100 miles, if in fact they could not come to Dublin for their surgery. I think it should be noted that 98 percent of our veterans admitted to our hospital are either service-connected or below the poverty level. So we see a large number of veterans that are below poverty level or they are service-connected.

As Mr. Duncan mentioned a lot of our patients probably would not go anywhere other than Dublin. They would not go to Augusta. Mr. Burnett has mentioned some problems that he has had with bed closures in surgery. I think that might present some problems for them providing our care. We have mentioned what the district chiefs of medical service have said after reviewing the recommendation of the ad hoc committee. They are in agreement that really that should stay at our hospital.

Dr. ROWLAND. Could you kind of summarize for us?

Mr. EDGAR. I will summarize it. Let me say that Dr. Allison mentioned that if the proviso could not be met of community back-up—It has already been stated that there is a limited community back-up. We have documentation which supports that, and if that is a proviso that we do not meet then we keep our surgery, I am confident that we will keep our surgery.

But in conclusion let me say that I think inpatient surgery is absolutely necessary. We are in the business of quality care, and it is hard for me to believe that we could provide quality care without inpatient surgery at a hospital.

[The prepared statement of Mr. Edgar appears on p. 41.]

Dr. ROWLAND. I believe he very clearly stated that he would not even have to take a second look at the recommendation if all the provisos could not be met, and apparently one of those provisos could not be met.

Mr. EDGAR. And I think we have sufficient evidence to show that that proviso could not be met.

Dr. ROWLAND. I want to thank all of you very much for your testimony.

The next panel is composed of Mr. Pete Wheeler, Commissioner from the Georgia Department of Veterans Service and a long time

friend of mine, Mr. William R. Head, Commander of the Georgia Disabled American Veterans and Mr. John Gwizdak, Commander of Department of Georgia Veterans of Foreign Wars and he is accompanied by Mr. Richard Branson. Gentlemen, if you would raise your right hands.

[Whereupon, the panel was sworn en masse.]

Dr. ROWLAND. Thank you very much for being here today.

STATEMENT OF PETE WHEELER, COMMISSIONER, GEORGIA DEPARTMENT OF VETERANS SERVICE, WILLIAM R. HEAD, COMMANDER, DEPARTMENT OF GEORGIA DISABLED AMERICAN VETERANS AND JOHN GWIZDAK, COMMANDER, DEPARTMENT OF GEORGIA VETERANS OF FOREIGN WARS

STATEMENT OF PETE WHEELER

Mr. WHEELER. Thank you very much. Congressman Harris from Alabama stated in his remarks a few minutes ago that he hoped that the testimony received here today would point the way to solving the problems facing all VA Hospitals. That is about what he said. I would like to comment on that before I go into the Dublin problem. The Veterans' Administration Administrator has spent most of the summer of this year going all over the United States of America talking to anybody that would listen, particularly veterans' organizations telling them that everything is all right. Everything is rosy. Everything is wonderful in the VA Hospital program. The chief medical director up until just a few weeks ago has been saying,"Amen. That is right, Mr. Administrator Everything is great. Everything is great." Now the answer and the solution.

We need an administrator and a chief medical director that will talk to their local, State hospital directors and ask them what they need and then come before you people in Congress and tell you the truth about what is needed for the Veterans' Administration to operate a good medical program and then for the Congress to pass the money and give us the money to operate the program. Now, that's what the problem is today in my opinion, and that is the solution, and hopefully that will be corrected in a few months.

First of all, we oppose the elimination of the inpatient surgical unit—the elimination of this surgical unit here at the Dublin VA Medical Center. We feel that this would be a drastic measure in a battle for economy and the VA's medical system.

Relegating veterans in need of surgery to lengthy travels to other VA medical centers in Atlanta, Augusta, and perhaps Charleston, South Carolina would in many instances, constitute unnecessary hardships on the veterans and their families, and sending them to other VA facilities would be the only alternative they have. Surveys made in and around Dublin—and I think that is the key to this whole thing, Congressman Rowland—stated that there would be no dependable surgical back-up from the private sector. Area physicians have already stated that their private citizen patients will have priority and rightly so. These doctors added that they definitely would not make themselves available to the Dublin VA Medical Center on an on-call basis for any type of surgery, whether it be routine or emergency.

Now, closing the surgical unit here at Dublin would be denying veterans in the central and southern area of our State, with a veterans population of over 110,000 veterans a branch of medical service which they deserve and which they should have available to them.

There is no doubt in my mind that the closing of the surgical unit here at Dublin will result in a deterioration of the overall quality of care here at the Dublin VA Medical Center. In my humble opinion a hospital without surgical capabilities is really not a hospital. In my opinion you would be turning this VA Medical facility into a high class nursing home. That is about what you would have here, and we do not want that here in Georgia.

We fail to see where any monetary savings would be realized with the closing of Dublins VA surgical unit. Transporting veterans in need of surgery to other VA facilities would be very costly with no possibility of surgery being available locally. I think that is the key to it. The chairman of the committee that made the study—you questioned him a minute ago, stated that with no possibilities of surgery being available locally on a contract basis that they would not close this facility, and that is what the case is. So I think the case ought to be closed and they ought to just come up here and say,"We made a mistake, Congressman. We want to just come up here and tell you that we made a big mistake and we are sorry, and it was caused by the fact that our administrator did not ask for the money that we need, and we are running around here trying to save money. That is all it is."

Dr. ROWLAND. I believe Congressman Harris has already referred to that as what we hear in Washington about that very point.

Mr. WHEELER. I think I can sum it up that the bottom line is that every dollar denied in the VA's budget means that America's veterans will be denied another dollar's worth of VA services, and I have confidence in you gentlemen, and your distinguished chairman, Sonny Montgomery, that I believe with a new President coming in, that Mr. Montgomery is a good friend of the new President, and I hope and I believe that he will go over there and explain to the new President what we need in the way of an administrator and what we need in the way of a chief medical director, and then we can get the show on the road and treat the veterans of this country, which we need to be doing. Thank you very much.

[The prepared statement of Mr. Wheeler appears on p. 67.]

Dr. ROWLAND. I believe we can count on Chairman Montgomery to do just exactly that. Mr. Head?

STATEMENT OF WILLIAM R. HEAD

Mr. HEAD. Mr. Chairman and distinquished panel members, a few comments need to be added to what has already been said and written, and it is a great privilege for me as Commander for the Department of Georgia Disabled American Veterans to be able to add to my written statement.

I am here this morning as a veteran, as are all of the service organization representatives who are here. We are trying to retain something for our fellow veterans that we feel is needed now and

well into the future. This is a need which becomes greater by the day.

The 110,000 veterans living in the 52 county area of south central Georgia serviced by the Carl Vinson Veterans' Administration Medical Center, in Dublin, need to be assured of prompt and timely quality care for their surgical needs. This is not available from the local community. This is not available by transportation the 100 miles to Augusta, or even greater distance of 135 miles to Atlanta, this much needed quality care is here and readily available at VAMC Dublin. Please do not take it away.

You must keep in mind that this VA Medical Center covers a large low income area of south central Georgia. The veterans served by the center are, in most cases, in that lower income bracket. They are, however, proud, and they do not want to force a problem onto the Veterans Administration. It is simply that as these veterans age, they are needing and looking for more help from the VA. These are the men and women who served, who now live with the barest of necessities and the lowest of incomes, and now have this great need to be helped. Please assure them of this help, which to them means, if not in full at least in great part, their very lives.

Mr. Chairman, I trust that your subcommittee will recognize the great need and will recommend continued surgical service at the Carl Vinson Medical Center, in Dublin. I trust that you will do all in your power to keep this service intact for our needy fellow veterans.

Thank you for allowing me to come before you to present the views of the Department of Georgia Disabled American Veterans. We are grateful for your keen interest and that of Congressman G.V. Sonny Montgomery. On behalf of all veterans and their families, but particularly those in south central Georgia, again, thank you all.

[The prepared statement of Mr. Head appears on p. 83.]

STATEMENT OF JOHN GWIZDAK

Dr. ROWLAND. Mr. Gwizdak? Did I get it right that time?

Mr. GWIZDAK. Yes, sir, real fine. Thank you, sir.

Mr. Chairman and members of the committee, thank you for the opportunity to present the views of the Georgia Department Veterans of Foreign Wars of the United States with respect to the budget impact on the delivery of VA medical care to rural veterans in the State of Georgia and the planning process related to closing surgical services at the Carl Vinson VAMC Dublin, Georgia. We, sir, are please that your subcommittee demonstrates an active and deserving concern for the quality of medical care provided to our veterans, particularly in the State of Georgia.

The continuing budget reductions aimed at our VA medical facilities is most alarming and has, and will adversely and very seriously affect both the quantity and quality of medical care provided. Georgia is primarily a rural State with more than 650,000 veterans. Approximately 48 percent of these veterans live in rural counties which are generally classified as medically underserved to the point of being impoverished. Since 1983, 61.5 percent of the total discharges for veterans residing in Georgia served by VAMC's At-

lanta, Augusta, and Dublin were veterans residing in rural areas. These veterans utilize VA medical care services at a much higher rate than those residing in metropolitan areas primarily because of reduced or inadequate medical facilities available in rural areas. Outpatient visits to Georgia VA medical centers have also significantly increased over the last few years by approximately 38 percent. This is primarily due to the costly inpatient care. During recent years, 46.5 percent of these outpatient visits have come from veterans living in our rural counties. As these statistics point out, our rural veteran population relies upon and depends on the VAMC's in our area for medical care which is now more than needed because of the aging factor. To date, the budget reductions for the VAMC's in Georgia have had a severe affect on personnel staffing, pharmacy services, repair and replacement of equipment, and the needed expansion and renovation of facilities. Without reservation, Mr. Chairman, this trend in the degradation of available medical care provided to the men and women who served our great nation is not deserved and should be reversed and turned around now.

Mr. Chairman, we realize that discontinuing surgical services at VAMC Dublin, Georgia is only in the committee/planning stage at this time. However, the Georgia Department of Veterans of Foreign Wars of the United States goes on record now to inform your subcommittee that we strongly oppose curtailing any surgical services currently being provided by VAMC Dublin. Regionalization of services is not the answer. The end result to our veteran patients would be to sacrifice the high quality and timely care that has been earned and should be due from a great nation. VAMC Dublin serves approximately 110,000 veterans. Yes, that number is sizeable and impressive. If surgical services are discontinued at this facility, there is nothing in the immediate area to handle emergency surgical requirements for our veterans and there is essentially no back-up available for other surgery. We do not believe that discontinuing surgical services at VMAC Dublin would increase efficiency for other VAMC surgical units in Medical District 9. It would be fallacious to assume that it would delete duplicating services. It is folly to suggest that it would redirect services and resources to a more cost-effective alternative. It is unrealistic to assume that a shifting of surgical resources from VAMC Dublin to a higher priority area would be economically prudent and the better part of wisdom. The inconvenience in travel, particularly under emergency conditions, and other sacrifices and the people problems generated should not be overlooked for they are real and human considerations. Mr. Chairman, the surgical services at Carl Vinson VAMC Dublin, Georgia, must remain operational to serve our veterans in this rural part of the State. We urge your best efforts to preserve that privilege and thank you for all you do in that endeavor and in that direction.

At this time I thank you from all the veterans for what you have already done for us. We continue to appreciate your service, sir, and your committee. Thank you, sir.

[The prepared statement of Mr. Gwizdak appears on p. 87.]

Dr. ROWLAND. As already pointed out by Congressman Harris and reemphasized by Commissioner Wheeler, what has been taking

place during the past several months or years referenced to how good things are for the VA, I just might ask all of you from the veterans' organizations to let all your members know to call and get in contact with Members of Congress and let them know how they feel about the VA and the budget process so that—this will be much more forceful in helping us deal with that problem in Washington.

Congressman Harris?

Mr. HARRIS. Amen.

Dr. ROWLAND. I like that fellow to be on a panel with me.

Thank you all very much for being here. I do appreciate it so very much.

The last panel is composed of my good friend Bubba Akin, Mr. Wilbur Keck, accompanied by Mr. Fred Asbell, past Commander of the American Ex-Prisoners of War, and Mr. Keck is the Commander of the Middle Georgia Chapter of American Ex-Prisoners of War. Mr. Akin is the service officer of the Department of Georgia, the American Legion, and Mr. Tom Grabowski is the president of Chapter 404, Air Force Sergeants' Association, and Mr. Curtis D. Smith, vice president of the Georgia-Carolina Chapter of the Paralyzed Veterans of America. Gentlemen, if you would raise your right hand.

[Whereupon, the panel was sworn en masse.]

Dr. ROWLAND. Again, I will say if you will summarize your statements and all of your statements will be made as part of the record without objections. Bubba? Mr. Akin?

STATEMENT OF A.V. BUBBA AKIN, SERVICE OFFICER, DEPARTMENT OF GEORGIA, THE AMERICAN LEGION, WILBUR KECK, COMMANDER, MIDDLE GEORGIA CHAPTER AMERICAN EX-PRISONERS OF WAR, TOM GRABOWSKI, PRESIDENT, CHAPTER 404, AIR FORCE SERGEANTS' ASSOCIATION

STATEMENT OF A.V. BUBBA AKIN

Mr. AKIN. Mr. Chairman and members of the subcommittee, the American Legion, Department of Georgia, is appreciative of this opportunity to present its views on the proposed closing of the surgical service here at Carl Vinson V.S. Medical Center.

Let me say that the American Legion continues to be the largest veterans organization nationwide, and here in Georgia where we represent more than 40,000 veterans of the four American wars in the 20th century residing in our State. That being so, we believe our voices should be heard in all crucial matters and we appreciate this opportunity that you now give us.

Mr. Chairman, I am not here to attempt to quote statistics and survey reports. They have been very well covered. Your panel has the expertise, and many in attendance here are familiar with all aspects of our current issues. This was well demonstrated by your Chairman Montgomery's recent published report of hearings with Administrator Turnage on inadequate staffing and resources system-wide.

I wish to speak for the veterans involved in the T.A.G. proposal and for our American Legion grass-roots, rural, post-level service officers throughout Georgia, who daily must face and counsel eligi-

ble veterans, their families, relatives, local elected officials, and, yes, even some congressional staffers who demand explanations as to why it is difficult and often impossible to obtain admission to a VA hospital. We service officers know quite well from hard experience that operating beds have been repeatedly reduced and are just not available.

We also know, Mr. Chairman, that the VA is not meeting its legally mandated responsibility of providing quality health care to veterans.

At our July National Convention in Louisville, KY, I must tell you the Associate Deputy Chief Medical Director was abruptly challenged in his remarks to our veterans affairs commission saying that DM&S was in fine shape, doing more with less, even with current budgetary constraints. The good doctor was then deluged with questions, some irate complaints and criticism from service officers nationwide concerning closures, denied admissions, inadequate staffing of nurses and technicians among others. There was no satisfactory rebuttal offered by the Central Office official and he left the room immediately.

Mr. Chairman, only 2 weeks ago our national executive committee meeting in Indianapolis was briefed on projected DM&S funding shortages for the current fiscal year and I quote,"The shortfall is expected to fall between $800 million and $1 billion. It is indicated that the VA will attempt to acquire a supplemental appropriation to provide relief in this area. Problem areas include severely restricting category B & C veterans, bed and unit closures, restriction of pharmaceuticals, increased waiting time in various types of clinics."

We of the legion are much concerned, Mr. Chairman, and members of the committee, that many of the veterans living in this area of south central Georgia and the Dublin PSA have now reached advanced ages with various infirmities that are requiring them to seek medical treatment and care for the first time. This urgent and increasing need is creating a tremendous demand on the VA health care facility here at Dublin as well as Atlanta and Augusta, where admissions are almost impossible under present conditions. This demand, regardless of varying opinions, is compounded by the fact that the greater majority of our veterans seeking surgical and other medical care are indigent and unable to pay for needed care in the private sector.

As active service officers we are convinced that decremental budgeting has had an adverse effect on patient care, both inpatient and outpatient and will continue to erode the quality, quantity and timeliness of health services provided our veteran beneficiaries. We heartily agree with your distinguished chairman in his praise and commendation of local administrative and medical staffs systemwide. He states that they deserve the accolades and the local management has kept veterans health care solvent in recent years. Mr. Chairman, as you well know, we have proclaimed that to be true here at Dublin.

The American Legion urges you to assist in total rejection of any proposals or recommendations of the T.A.G., Regional Task Advisory Group, to close surgical service at this medical center. Middle Georgia veterans can ill-afford to lose this needed medical care for

whatever reasons, and further, we sincerely request that Congress commit themselves to providing adequate funds to assure that all authorized beds are fully staffed, operational and readily available.

Our national leadership will continue to emphasize the need for additional resources for the VA health care system. Securing these additional resources will be at the forefront of our legislation involvement in the coming Congress.

We too are most concerned about the VA leadership's continuing effort to disguise reality and do nothing to remedy what is widely recognized as a crisis imposed upon our veterans by the Office of Management and Budget.

In closing, Mr. Chairman, the American Legion, Department of Georgia, does not seek more from the Federal Government than we believe are the just dues of the men and women from our State who have answered the call of the elected Government to defend the national interest in the Armed Forces.

We too know well the dedication and interest of your chairman and members of this committee and of the full committee on Veterans' Affairs in ensuring for the legitimate needs and care of our disabled and sick veterans. We commend you, sir, for your dedication and for your efforts in our behalf.

Thank you again for this opportunity.

[The prepared statement of Mr. Akin appears on p. 89.]

STATEMENT OF WILBUR KECK

Mr. KECK. I am honored to appear before you today.

I am Wilbur H. Keck. I represent the Middle Georgia Chapter of the Ex-POW's and the Carl Vinson Memorial Chapter, Air Force Association. I am Commander of the American Ex-POW Chapter with 50 members. I am the past State president of the Georgia AFA and currently on the Board of Directors of the Carl Vinson Memorial Chapter with 3,800 members.

I was a Prisoner of War in Europe during World War II. Later I flew 55 combat missions as a pilot in Korea. I retired from the Air Force after 21 years of active military service. I then served 23 years as a civil service employee with the Air Force. I am now retired after 44 years of honorable service.

The Macon Telegraph and News Article, the 29th of September, concerning the VA proposal for closing the inpatient surgery unit here at Dublin was a total shock to our members. It was as if after 44 years we had found a friend only to find the VA was going to render it impotent. I guess the real problem in our minds is, if this is closed this year, what will be next?

We Ex-POW's are a unique group. Generally speaking we were a forgotten group of veterans so far as the United States Government, military and citizenry were concerned.

As Ex-POW's we had no record of our combat injuries or other service-connected disabilities. We had no medical record of any treatment of these conditions. We had no personnel records for the period of confinement. Upon return we were herded around like cattle until we faded away—discharged or blended into the non-POW military force. We lost many promotion opportunities due to our lack of performance ratings while confined. We were separated

early because of the lack of this promotion opportunity. Until recently the VA would not adequately adjudicate our claims because of the lack of proof of injury and treatment. The citizenry had little understanding and no patience with the plight of Ex-POW's.

The Carl Vinson VA Medical Center has changed much of that. The staff here has made every attempt to reverse this situation and recognize the Ex-POW's plights. During the two years of our organization, the Dublin staff has provided speakers for our group and rendered medical service which has changed the attitude of our members. During this period I have heard nothing but praise for the services rendered by this medical center and its staff.

The media report that this medical center may lose its inpatient surgical unit has had a demoralizing effect on members of our chapter and chapters in South Georgia.

I view the services rendered by the Veterans' Administration as tantamount to the national debt. It is a debt the country is responsible to adequately fund and pay in full. We cannot continue to defer payment when the quality of life of disabled veterans is the penalty.

I cannot address the efficiencies or inefficiencies of the VA, but I can assure you that this medical center is trying to do its part in paying off the national debt. They have instilled confidence in all disabled veterans concerning this country's resolve to take care of its vets.

It would appear to be more feasible to reduce the staff in the large cities such as Atlanta and Augusta. In those locations major civilian and military medical centers, such as Emory and Fort Gordon, are within minutes.

The adjudication and appeal system consumes excessive manhours. Since Ex-POW's have no record of combat injuries and medical treatment, it would appear that a system of applying a fixed percentage disability based on doctor's certificates of the existence of presumptive disease would save many hours for adjudicating officers. We also find that the Atlanta area will not recognize the Dublin's doctors statements and usually examinations have to be repeated when we come to the adjudication stage.

In closing, I beg that you will consider the impact on the disabled vets in middle and south Georgia when making decisions. The reduction of services here at Dublin will negate all the good work the staff has been doing for our vets. Also it will be demoralizing for those who need these services. It will be even more devastating if one of our vets should die because of the distance to travel to get emergency treatment. I believe there are other options available to the VA which will render equal savings without adversely affecting the middle and south Georgia vets.

The most difficult for Ex-POW's and disabled veterans to understand is how Congress can give Japanese-Americans interned during World War II $2 billion, and most recently the appropriation of more than $500 million a year in foreign aid to the Philippines while they are cutting VA services.

Please do not allow the VA to default on their responsibility to pay our national debt to the American veterans. Thank you for allowing me to plead our case.

STATEMENT OF THOMAS GRABOWSKI

Mr. GRABOWSKI. Congressman Rowland, Congressman Harris, recently the Air Force Sergeants Association was informed about this panel's meeting, and would like to take this opportunity to express our view. This was a joint paper prepared by my wife and myself. She is the president of the Auxiliary, and as VAVS volunteers and presidents of our respective organizations we wish to address this issue and expressed our feelings of the tremendous negative impact it would have if we were to remove the surgical unit.

We are sure that most of the panel is aware of the fact that Dublin's facility serves 52 counties and 110,000 veterans.

We find that the recommendations that Region 9 is calling for—for the surgical unit to be closed— is, in the politest term we can find, absurd.

Taking away a benefit from those who have earned it, by paying a price most would find next to impossible to pay, is not the answer.

Surgical consultation is vital and oftentimes is required in a matter of minutes, 24 hours a day, 7 days a week with followup by the surgeon. How can we ask those veterans, who may require this immediate care to be expected to face a 3- or 4-hour ride to another facility for consultation and treatment? In cases of scheduled surgery the waiting period would be long and in many cases require the services of a nurse to travel with the patient to the other facility.

If the surgery program is removed, patients would suffer, some possibly even die. Physicians would leave this facility. Acute medicine would ultimately be closed and at best reduce the Dublin facility to a nursing home and mental health facility and then with only limited capability. We do not need or want another nursing home in the immediate or surrounding area. We need the full service hospital we have here at Dublin.

The excellent patient care we have experienced over the years we have been associated with the Dublin VA Center, in addition to the positive happy attitude of the patients, staff and volunteers, certainly must show this committee that quality care and patient concern are the primary mission of the Dublin VA Hospital. The very fiber of our great country is founded upon the principles of life, liberty and the pursuit of happiness. Can you or anyone comfortably endorse a program which threatens our most cherished entitlement? Life.

The Congress and the American people have traditionally demanded quality medical care for our veterans. The proposal to close the surgical services at the Dublin VA Medical Center would without question not only violate this mandate, it would destroy it.

At a time in their lives when medical attention and care are critical, the veterans ask only the same consideration they provided when they performed their service—quality, availability, expediency and professionalism. There was never a time during their tenure that they discussed what impact cutting down their services would have on the American people. They gave their full measure and often a touch more, and far too many gave the ultimate price, but those remaining still carried on and provided what they know this

country expected—complete dedication to Americans taking care of Americans. Can we offer anything less? Thank you.

[The prepared statement of Mr. Grabowski appears on p. 92.]

Dr. ROWLAND. Thank you very much. We want to thank all of your for coming today. Congressman Harris?

Mr. HARRIS. I just would echo that and say that I certainly enjoyed the testimony of all the witnesses, and before I forget it, I just want to brag on your Congressman Roy Rowland. He is a good man. Keep sending him up there.

Dr. ROWLAND. See why I brought him? Mr. Keck?

Mr. KECK. If Mr. Asbell could make a little speech. He came here to us because I was a career military man and he was one who got out right after World War II and if——

Dr. ROWLAND. Sure. I thought Mr. Asbell would just accompanying you, and usually the person accompanying the one who testifies does not. So, sure, we will be glad to recognize him. Mr. Asbell?

STATEMENT OF FRED ASBELL

My name is Fred W. Asbell. I, too, am representating the Middle Georgia Chapter of American Ex-Prisoners of War and my fellow veterans.

I am the immediate past Commander of the Middle Georgia Chapter of American Ex-POW's. I have had the distinct privilege of being the charter Commander of this group and am proud to be their representative at this hearing.

After 9 months of flying combat and having been shot down over Germany in World War II, I know what war is like. I am also knowledgeable about the many, many hardships and brutalities we endured while held as prisoners by the enemies of the United States.

I regret that our Congress does not have a better and more thorough knowledge of our country's wars, and the trials, tribulations, torture and hunger, and other hardships that befell our veterans. I make this statement because I do not believe that any person would deny relief, comfort, and a decent quality of life to our veterans in order to accomplish many of the other projects (many are politically motivated) which our Congress so readily endorses.

Our veterans and veterans' facilities have been "short changed" and denied the funds to provide the necessities for a decent quality of life for the veterans and their families.

Most veterans of World War II are between 65 and 70 years of age. What did the Tax Reform Act of 1986 do for the veterans?

(1) It eliminated the extra deduction for age 65 and over;

(2) It eliminated the extra deductions for those and their spouses who are blind;

(3) For many veterans who have worked hard and saved for our later years it taxes our social security benefits;

(4) An increase from 5 percent to 7.5 percent of income for medical expenses.

The new Catastrophic Medical Insurance bill will surely hit many of our veterans hard. The premium of 15 percent for each $150 of income tax will hurt the veterans who are already carrying their own medical insurance in addition to Medicare.

The Veterans' Administration has changed its policy on "travel pay" for veterans needing medical services. Many of these veterans are unable to pay their bus fare or buy gas, yet the VA has tacked on a $6 deductible from the travel pay thus reducing it from 11 cents per mile to about 5.5 cents per mile. Some VA facilities will not pay travel pay for veterans scheduled by another VA facility.

Will our spouses be given a flag, and a grave marker when we "pass on"? Not if the current trend continues.

Really are there no funds available for VA facilities and veteran's benefits? Can our Congress not make funds available so that the VA hospitals can hire doctors who can speak and understand English? Have you ever been frustrated by someone you can't understand? There are too many medical assistants in the VA hospitals. They are good, but they are not as knowledgeable as trained doctors and surgeons.

However, our Congress can find funds for the Japanese Americans—$2 billion—who did have adequate food, clothing and warm shelter during the time our veterans POW's did without.

Our Congress can find funds to educate certain groups who spend the money unwisely and fail to repay their loans.

Our Congress can find millions of dollars to promote, support, and protect, people running for political office.

Our Congress can find funds for welfare recipients who are able to work but don't, for wed and unwed mothers who have more children to increase the size of their welfare check.

Our Congress can find funds for environmental studies and projects like freeing three whales from the ice in Alaska.

We do find funds to support many foreign governments, even after giving away the Panama Canal to one of them.

The veterans gave the best years of their lives for this great country in which you and I live. Please lets find the necessary funds to insure our veterans a good quality of life in the few years they have left to live.

As my friend Wilbur Keck has stated, the Carl Vinson VA Medical Center has been a "bright spot" or "an oasis" for our middle Georgia veterans. Mr. William Edgars, Mrs. Pat Oliver, Dr. Maurice Arnold and all members of the staff of the Dublin facility have provided every service available to them for our middle Georgia veterans. May God give us more facilities staffed with more people of compassion like the Carl Vinson Medical Center in Dublin, GA.

Dr. ROWLAND. We would like to thank also all those people who submitted testimony for the record who wanted to focus in this hearing on a couple of things—the severe problem that we are getting into so far as underfunding in our budget is concerned—I think we did that very well, very adequately—and the initial proposal to remove the inpatient surgery unit here at the Carl Vinson VA Medical Center. I think we focused on that very well also and pointed out to the panel that they were not able to meet all the provisos, and you heard the chairman of that panel saying that if all of them were not met, then he would not have to even take a second look at the recommendation. So I think perhaps we have accomplished what we wanted to do here today. I want to thank all of you very much again for being here, and we stand adjourned.

[Whereupon, the hearing was adjourned at 12:10 p.m.]

APPENDIX

Testimony of
Donald B. Thompson
Regional Director
VA Southeastern Region
The Select Subcommittee of
Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives

Friday, December 2, 1988

Dublin, Georgia

Mr. Chairman, members of the Subcommittee, and guests, it is an honor for me to be here today to represent the Veterans Administration, and to discuss the health care needs of veterans in the Carl Vinson VA Medical Center service area as well as other areas throughout the Southeastern Region. I am pleased to have the opportunity to provide you with this overview and then respond to any questions you may have.

As Director of the Southeastern Region, I have been asked to present my position on two issues of importance to veterans, not only in this area, but in other areas of the Southeastern Region as well.

The first issue I will discuss is the provision of rural health care for veterans in the Southeastern Region and in the service area of the Carl Vinson VAMC. My position is that VA facilities must provide care for veterans whose care is mandated. Actions that we have taken indicate our commitment to placing health care services where they are needed, be it in a rural or urban setting.

The Carl Vinson Medical Center is a fully operational primary and secondary care hospital, making appropriate tertiary referrals as

needed, and adequately providing for the health care needs of the veterans it serves. I feel that the facility has experienced no significant problems in delivering health care to its veteran population. The facility has received its share of recurring dollars made available to the Region and will continue to do so provided it remains efficient and cost effective in its operation while maintaining its level and quality of care.

Since 1983, the medical center has seen its recurring resource base increase by over 38%, or $9 million dollars rising from nearly $23 million in 1983 to approximately $32 million in 1989. Its employment also increased by 50 positions during this same period. As Regional Director, I have also funded two MEDIPP actions at Dublin this past fiscal year which provided for an initial Psychiatric Bed Service capability and a Mental Hygiene Clinic. Recurring resources in the amount of $1,300,000 and 41 FTEE were provided to the medical center for these initiatives. These monies constitute nearly 33% of the total recurring dollars made available to me for new program initiatives for all 21 medical centers in this Region. In FY 1987, the medical center also received 7.4 FTEE and $212,000 in another MEDIPP initiative to convert 30 medical beds to an Alcohol Treatment Unit to serve the area and other district needs. Since 1982, I have also provided $2,597,739 in recurring and nonrecurring Region operational funds to the medical center for other programs.

I'd now like to focus on the subject that has seemed to raise much anxiety in this particular community over the past few months regarding, the "planned" closure of Surgical Service at the Carl Vinson VA Medical Center. First I must state that there is no approved planned closure at this time.

This subject is being addressed by an ad hoc task force established within Medical District 9 to review the Surgical Service at the Carl Vinson Medical Center and determine what

level of Surgical Service should be provided at the facility, considering such issues as opportunities to regionalize services without compromise to quality. The Task Force's report has been sent to the Regionalization Technical Advisory Group for the District, but has not been referred to the District Planning Board or the District Executive Council. Both groups must make a final recommendation to me prior to my review.

This Task Force report, as a part of the district planning process, must now withstand both district and regional reviews. If the district endorses the report and forwards it as a formal proposal, the Region Planning Board will critically evaluate it before any action is recommended to me with regard to what would constitute a basic mission change for a facility.

My first concern, should a formal proposal come to me, would be the degree to which a recommendation to close the surgical unit is based upon an assessment of the quality of the services provided and the qualifications of the staff. I can say without hesitation that if it were determined to be of poor quality, I would close the unit. This does not appear to be the case in this instance.

In considering this particular recommendation, if it comes to me, I would determine the effect any such closure would have on the veteran being served by the Dublin facility. I would have to be assured that alternate sources of care are available and that the quality and costs of those alternatives are appropriate. Further, I would require documentation on how affected employees would be accommodated and that they could be properly reassigned to other jobs. I would require an implementation plan to assure that transfers between medical centers were made at minimal inconvenience and discomfort to the patient. I would also require a formal assessment of the ability of the Carl Vinson VAMC to recruit qualified staff in other disciplines should surgical services be eliminated from their mission. My personal

opinion is that every facility that is operated as a hospital should have the capability to provide basic ambulatory and inpatient surgical care at the primary and nonspecialized secondary level. Moving all veterans needing minor surgery to a tertiary care medical center is, to me, a false economy. I reiterate that I have seen no formal recommendation from Medical District 9 to close the Surgical Service and therefore have made no decision on a mission change for the Carl Vinson VA Medical Center.

Mr. Chairman, I would like to add, however, that I fully support the continuation of this process of review and assessment in the Medical District 9 MEDIPP process. They must have the opportunity to objectively look at all services in all medical centers and to recommend appropriate changes. We all recognize that these are difficult times, financially. The rising costs in health care present a challenge to all of us and we must manage our resources with ever increasing efficiency and effectiveness. We must never discourage health care professionals from studying and restudying every possible avenue and alternative available to be more cost effective. Our overriding concern and objective, however, must be to reduce costs without compromising quality. These are the considerations which will guide my decisions in any mission plans.

This concludes my final remarks. I wish to express my appreciation to the Subcommittee for the opportunity to appear. I will be pleased to respond to any questions you may have.

STATEMENT OF WILLIAM O. EDGAR
DIRECTOR, CARL VINSON VAMC

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE AND DISTINGUISHED GUESTS, ON BEHALF OF OUR PATIENTS AND STAFF I WELCOME YOU TO OUR MEDICAL CENTER FOR THIS VERY IMPORTANT HEARING AND APPRECIATE THE OPPORTUNITY TO ADDRESS THE CHALLENGES WE FACE IN THE DELIVERY OF HEALTH CARE TO OUR VETERANS IN THE CURRENT SITUATION OF A TIGHTENING BUDGET AND FUTURE LIMITED RESOURCES.

BEFORE I RESPOND TO YOUR QUESTIONS CONCERNING THE ISSUE OF SURGERY AT DUBLIN, I WOULD LIKE TO SAY THAT THE REVIEW OF "WHAT LEVEL OF SURGICAL SERVICES SHOULD BE PROVIDED AT DUBLIN VAMC" HAS JUST BEGUN. IT IS IN THE INITIAL STAGES OF WHAT WE CALL THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING PROCESS. THIS PROCESS IS VERY LENGTHY AND THOROUGH AND MUST PASS THROUGH MANY REVIEW LEVELS BEFORE ANY FINAL DECISION IS MADE. IT IS IMPORTANT TO POINT OUT THAT THESE REVIEWS ARE EXTREMELY IMPORTANT TO THE VA PLANNING PROCESS AND ANY RECOMMENDATIONS PRESENTED AS A RESULT OF THESE REVIEWS MUST WITHSTAND BOTH DISTRICT AND REGIONAL PLANNING SCRUTINY.

WHERE ARE WE NOW IN THE MEDIPP PLANNING PROCESS.

AN "AD HOC TASK FORCE" HAS BEEN CONVENED, IT HAS CONDUCTED AN ON-SITE VISIT AND SUBSEQUENTLY SUBMITTED A REPORT TO THE CHAIRMAN OF THE DISTRICT'S REGIONALIZATION TECHNICAL ADVISORY GROUP. THE REPORT CONTAINED A RECOMMENDATION THAT THE DUBLIN VAMC INPATIENT SURGICAL PROGRAM BE CLOSED AND WE RETAIN ONLY A MINOR SURGERY PRESENCE AT OUR FACILITY. WE HAVE BEEN PROVIDED A COPY OF THE "AD HOC TASK FORCE" REPORT AND ON AUGUST 10, 1988, WE RESPONDED WITH OUR COMMENTS ON THEIR REPORT TO THE CHAIRMAN, REGIONALIZATION TECHNICAL ADVISORY GROUP. THE RECOMMENDAION AND

OUR RESPONSE ARE CURRENTLY IN THE HANDS OF THE REGIONALIZATION T.A.G. COMMITTEE FOR THEIR REVIEW AND RECOMMENDATIONS TO THE DISTRICT PLANNING COMMITTEE. SIMPLY STATED OUR RESPONSE TO THE REPORT THANKED THEM FOR THEIR EFFORT AND DISAGREED WITH THEIR RECOMMENDATION. OUR REASONS FOR DISAGREEMENT CENTERED AROUND:

1. QUALITY OF CARE
2. ACCESSIBILITY OF CARE FROM THE PATIENT'S VIEWPOINT
3. COST ISSUES
4. ASSOCIATED RECRUITMENT PROBLEMS
5. LACK OF ABILITY IN THE COMMUNITY TO PROVIDE SURGICAL BACKUP SUPPORT.

I AM HOPEFUL THAT BASED UPON INFORMATION PROVIDED IN OUR RESPONSE TO THE REGIONALIZATION COMMITTEE, THEY WILL COME TO THE CONCLUSION THAT THE INPATIENT SURGICAL PROGRAM SHOULD REMAIN AT THIS MEDICAL CENTER.

WE FEEL IT IS IN THE BEST INTEREST OF THE VETERANS IN OUR PSA AND THE MEDICAL DISTRICT THAT INPATIENT SURGERY REMAIN AT OUR HOSPITAL.

WE SHOULD REMAIN A GENERAL MEDICAL - SURGICAL FACILITY THAT PROVIDES BOTH ACUTE SERVICES AND LONG TERM CARE TO OUR VETERANS. I THINK OUR MINIMAL SURGICAL PRESENCE AS PRESENTLY CONFIGURED COMPLEMENTS AN EXCELLENT ACUTE CARE MEDICAL SERVICE AND DEVELOPING PSYCHIATRY SERVICE.

THIS IS THE SECOND FULL SCALE REVIEW OF OUR SURGICAL SERVICE IN THE LAST FIVE YEARS. THE PREVIOUS REVIEW CONCLUDED IN 1983 THAT NOT ONLY WAS THE COMPLETE PROGRAM REQUIRED BUT THE NUMBER OF BEDS SHOULD BE INCREASED TO AT LEAST 40.

IN MY OPINION OUR HOSPITAL IS WHAT THE 110,000 VETERANS IN OUR 52 COUNTY PRIMARY SERVICE AREA REQUIRE, A GENERAL MEDICAL AND SURGICAL HOSPITAL.

OUR SMALL BUT EFFECTIVE SURGICAL SERVICE PROVIDES QUALITY CARE WITH A VERY HIGH DEGREE OF SATISFACTION TO OUR VETERANS. WE DO GOOD GENERAL SURGERY WHILE REFERRING THE MORE COMPLICATED CASES TO OUR TERTIARY CARE SISTER HOSPITALS IN THIS DISTRICT AFTER PERFORMING APPROPRIATE EVALUATIONS AND PREOPERATIVE WORKUPS. I THINK WE ARE VERY GOOD AT WHAT WE DO AND DO IT IN A COST EFFECTIVE MANNER.

THERE HAS NEVER BEEN ANY QUESTION ABOUT THE QUALITY OF OUR SURGICAL SERVICE CARE.

WE ARE DIFFERENT IN THAT WE ARE THE ONLY VAMC IN A RURAL SETTING IN THIS MEDICAL DISTRICT. WE ARE 100 MILES FROM THE NEAREST VAMC, AUGUSTA, 135 MILES FROM OUR ATLANTA HOSPITAL, 171 MILES FROM OUR COLUMBIA, S.C. HOSPITAL AND 206 MILES FROM OUR CHARLESTON, S.C. V. A. MEDICAL CENTER.

IN TERMS OF GEOGRAPHICAL SIZE WE HAVE THE LARGEST AREA IN THE DISTRICT. MOST OF THIS AREA IS IN A PREDOMINANTLY RURAL SETTING. THERE IS ALREADY A PROBLEM FOR A NUMBER OF OUR VETERANS REGARDING ACCESSIBILITY OF CARE TO OUR CURRENT INPATIENT SURGICAL SERVICE. TO ELIMINATE THAT CAPABILITY WOULD EXACERBATE AN ALREADY DIFFICULT ACCESS PROBLEMS TO VETERANS.

WE SAW AN INCREASE IN PATIENTS COMING FROM THE SOUTHERN PARTS OF GEORGIA FOR SURGERY AT OUR VAMC THIS PAST YEAR. IT INCREASED FROM 100 IN FY 87 TO OVER 200 IN FY 88. WITHOUT INPATIENT SURGERY, THIS GROUP OF PATIENTS WOULD HAVE TO TRAVEL AN

ADDITIONAL 100 MILES TO RECEIVE THEIR SURGERY IN AUGUSTA. MORE THAN 25% OF OUR CURRENT PATIENTS WOULD HAVE TO TRAVEL AN ADDITIONAL 100 MILES FOR SURGICAL CARE IF WE LOST INPATIENT SURGERY.

IT SHOULD BE NOTED THAT 98% OF OUR VETERANS ADMITTED TO THIS FACILITY ARE EITHER SERVICE CONNECTED OR BELOW THE POVERTY LEVEL. SOME OF THOSE PATIENTS HAVE NEVER BEEN TO AUGUSTA OR ATLANTA OR CHARLESTON AND NEVER WILL. THEY JUST MAY NOT RECEIVE MEDICAL CARE. I WORRY ABOUT THOSE VETERANS. I WOULD ALSO WORRY THAT THE LOSS OF OUR INPATIENT SURGERY WOULD MEAN AN INCREASE OF WORKLOAD FOR OUR SISTER HOSPITALS, PARTICULARLY AUGUSTA. RECENT SURGICAL WARD CLOSURES BECAUSE OF RN SHORTAGE:

ATLANTA	38	12 (2 RN's, 7 LPN's, 3 NA's)
AUGUSTA	35	7
	4 OF 10	
	SCIU BEDS	4.6 RN's
CHARLESTON	18 SURGICAL	4.3 RN'S
TOTAL	95	27.9

ASSOCIATED RECRUITMENT PROBLEMS

THE DISTRICT CHIEFS OF MEDICAL SERVICES HAVE REVIEWED THE RECOMMENDATION TO ELIMINATE OUR INPATIENT SURGERY AND IT IS THEIR CONSENSUS THAT WE WOULD EXPERIENCE DIFFICULTY IN BOTH RECRUITMENT/RETENTION OF PHYSICIANS. IT IS THEIR OPINION WE WOULD BE ESPECIALLY LIMITED IN OUR ABILITY TO RECRUIT SUBSPECIALISTS WHOSE INVASIVE PROCEDURES REQUIRE SURGICAL BACKUP. THEY STATED WITHOUT GOOD SURGERY IT IS DIFFICULT TO IMAGINE HOW DUBLIN COULD RECRUIT AND KEEP A GASTROENTEROLOGIST OR A

NEPHROLOGIST MUCH LESS FEEL COMFORTABLE TREATING A VARIETY OF COMMON DISORDERS SUCH AS GI BLEEDING, PULMONARY HEMORRHAGE, SEVERE NOSE BLEEDS, DEEP SOFT TISSUE INFECTIONS AND OTHERS. MY CURRENT UROLOGIST HAS ALREADY TOLD ME HE WOULD LEAVE. IT TOOK ME OVER A YEAR TO RECRUIT HIM. HE DOES AN EXCELLENT JOB AND ENJOYS THE TOWN OF DUBLIN AND HIS WORK. TWO OF MY THREE SURGEONS HAVE INDICATED THEY WOULD LEAVE ASAP IF A DECISION IS MADE TO CLOSE INPATIENT SURGERY.

THE DISTRICT CHIEFS OF MEDICAL SERVICES FURTHER STATED IN THEIR REVIEW - QUOTE - "WITHOUT SURGICAL BACKUP THE LOSS WOULD NEGATIVELY IMPACT ON THE QUALITY OF MEDICAL CARE AND IMPAIR THEIR ABILITY TO ATTRACT THE PHYSICIANS NECESSARY TO RUN AN ACUTE MEDICAL SERVICE AND AT THE SAME TIME LEAD TO REDUCED FUNCTIONS AS PATIENTS WOULD LOOK FOR OTHER MEDICAL RESOURCES."

IN SEPTEMBER OF THIS YEAR WE OPENED A 30-BED PSYCHIATRY UNIT FOR ACUTE AND LONG TERM CARE. THIS ACTIVATION CREATES AN INCREASED DEMAND FOR INPATIENT SURGERY TO HANDLE THIS ADDITIONAL WORKLOAD. I MUST ADD THERE IS NO COMMUNITY BACKUP TO HANDLE THIS TYPE OF PATIENT FOR INPATIENT SURGERY NEEDS.

<u>COMMUNITY BACKUP</u>

THERE IS A VERY LIMITED COMMUNITY BACKUP FOR SURGERY. THE LOCAL HOSPITAL ADMINISTRATOR HAS STATED HE DOES NOT FEEL HIS HOSPITAL COULD PROVIDE ADEQUATE SUPPORT OR BACKUP TO OUR FACILITY AT THE PRESENT TIME AND THE STATUS IS LIKELY NOT TO CHANGE IN THE FUTURE. HE HAS ALSO STATED UNEQUIVOCALLY THEY DO NOT HAVE CAPABILITY OF MANAGING PSYCHIATRIC PATIENTS REQUIRING SURGICAL PROCEDURES.

WE HAVE ALSO TALKED WITH OUR LOCAL SURGEONS AND ONLY ONE EXPRESSED AN INTEREST IN PROVIDING SURGICAL ASSISTANCE AND THAT WAS FOR THOSE PATIENTS WHO WERE OF AN ACUTE NATURE AND ONLY THEN WHEN HIS TIME WOULD ALLOW IT. HE ALSO STATED HE COULD NOT GUARANTEE ROUTINE BACK-UP OR ON-CALL FOR OUR SURGERY NEEDS.
IT WOULD ALSO BE NECESSARY FOR US TO NEGOTIATE UP TO FIVE CONTRACTS WITH LOCAL PHYSICIANS AND SERVICES IN ORDER FOR THE LOCAL HOSPITAL TO PROVIDE SURGERY SUPPORT/BACK-UP. (SURGEONS, RADIOLOGISTS, ANESTHESIOLOGISTS, HOSPITAL, PATHOLOGISTS). THE TASK FORCE STATES THAT ONE SURGEON AND ONE UROLOGIST WOULD REMAIN AT THIS VAMC. LAST YEAR OUR SURGERY SERVICE PROVIDED 7781 CONSULTATIONS, DID 2400 MINOR PROCEDURES, SAW 6,000 VETERANS ON OUTPATIENT VISITS AND PERFORMED MEDICAL OFFICER OF THE DAY DUTIES. ONE SURGEON AND A UROLOGIST CANNOT HANDLE THIS WORKLOAD.

<u>COST ISSUE</u>

OVERALL COST FOR INPATIENT SURGERY FOR FY 87 WAS $1.8 MILLION.
OVERALL COST FOR INPATIENT SURGERY FOR FY 88 WAS $1.40 MILLION.
THE REQUIRED MINIMAL PROGRAM WE FEEL WILL COST ABOUT $1.6 MILLION USING WHAT SURGICAL TASK FORCE SPECIFIES AS A MINIMUM.
WE ASSUME THAT WE WILL CONTINUE TO PERFORM THE PREOPERATIVE WORKLOAD AND POSTOPERATIVE CARE AS WE NOW DO FOR VAMC AUGUSTA.
WE FEEL THIS WILL REQUIRE A SMALLER BED SERVICE OF 15 BEDS.
SAVINGS WOULD BE ABOUT $300,000. SAVINGS IS MAINLY FROM REDUCTION OF 18 FTEE FOR A PREVIOUS TOTAL OF 45.6 DIRECT CARE EMPLOYEES WHOSE COSTS WERE ATTRIBUTED TO SURGERY.
THIS SMALL REDUCTION IN STAFF AND DOLLAR SAVINGS IS NOT IN MY OPINION WORTH THE INCREASED ACCESSIBILITY PROBLEMS, ASSOCIATED

RECRUITMENT PROBLEMS FOR THE HOSPITAL AND INCREASED QUALITY OF CARE CONCERNS. THIS $300,000 SAVINGS COULD BE ELIMINATED IF THE CONSERVATIVE ESTIMATE OF THE AD HOC TASK FORCE FOR SURGERY DONE BY THE COMMUNITY WERE TO INCREASE.

STATEMENT OF HAROLD DUNCAN

HEARING ON CLOSING THE SURGICAL SERVICE AT CARL VINSON MEDICAL CENTER AT DUBLIN, GEORGIA

Mr. Chairman and other distinguished Congressmen, I want to express my appreciation to this committee for the privilege of testifying at this most significant event in the long and illustrious history of this hospital, now proudly named the Carl Vinson Medical Center after a man most of you knew and admired.

I am no longer employed by the Veterans Administration so I now speak for the Middle Georgia community, but with the perspective of a former Director of this Medical Center, and a former Medical District Director of this Medical District. And I speak in strong support of this hospital and its Surgical Service.

It has been recommended that the Dublin Inpatient Surgical Program be closed and that alternative resources and facilities be provided without detriment to the quality of care, increasing costs, or diminishing access to care in the Dublin primary service area. It is the thrust of my testimony that within these parameters, this is not possible.

In the National Football League there is a thing called instant replay. It focuses a different camera upon the same play from a different angle and comes up with an entirely different perspective and frequently a different ruling. And that is what I will be striving for during the next few minutes.

I understand that education, training residents and research programs are legitimate and necessary hospital functions, but the primary function is patient care. Here and now we have a small but effective surgical service providing quality general surgical care with a high degree of patient satisfaction, and a great deal of community support at a relatively low cost. If you are not aware of this reputation, I see Mr. Pete Wheeler and Mr. Bubba Akin in this audience, both highly respected representatives of the Georgia Departments and I would request that they testify to this point when they be permitted to speak.

To substitute for this caring service, it is proposed to retain one surgeon on duty in this office with no major operating suite. He will interview/examine prospective patients here in Dublin, place them in an ambulance and transport them to the Augusta affiliated hospital, 100 miles across the state. Emergency cases would be admitted immediately, but elective cases would be admitted within priorities established by that hospital, within a 6 week period to work our cases in with theirs. This procedure would present several problems.

One of the factors involved in the Dublin patient satisfaction quotient is its position near the center of its

primary service area with ready access to its patients and their families for support. However, this is a rural area and we have patients and their families who have never been to Augusta in their lives, and never will! There would be a problem in supplying family support. There would be problems in arranging transportation including staff support for emergency cases, transportation expenses including staff overtime, and scheduling elective cases. In the past when it has been necessary to refer cases to Augusta for specialized treatment, there has been a relatively high percentage of broken appointments. This is a diminished rather than an improved level of patient care.

Perhaps the impact of the proposal upon professional service other than surgical is even more traumatic. To say that the professional staff is concerned is a woeful understatement--their morale is at an all-time low. They are convinced that their patients will suffer, that their careers are in jeopardy because they will not be able to fulfill their responsibilities under the circumstances that exist, and that recruitment of qualified physicians, always a problem in rural areas, will become virtually non-existent. In the streets the natives are restless and this is not a gossipy town--just a highly supportive one.

Partly in response to these concerns, the District Regionalization Committee asked the District Chiefs of Medicine Committee to review the question of closure of the Dublin Surgical Service and to estimate its impact upon the recruitment and retention of physicians, support to Medical Service beds, and support to acute Medicine beds. The Chiefs of Medicine Committee consists of the Chiefs of Medical Service of the five hospitals in this Medical District--Charleston, Columbia, Atlanta, Dublin, and Augusta. That committee reviewed the Regionalization Committee minutes, the final report and recommendation of the Review Team sent to evaluate Dublin's Surgical program and Dublin's response to the Review Team's recommendations. In addition, they canvassed the Chiefs of Medical Service at VA installations now operating in the procedure recommended for Dublin.

A total of 12 such hospitals were contacted. One reported no difficulties since it was located in a thriving medical community. The others expressed varying degrees of disenchantment ranging from mild to indignation. Excerpts from the following three responses represent an interesting sample:

"It is an absolutely absurd way of practicing medicine. It exists only in the VA. Such an arrangement would not survive in the private practice. We have to send patients to (a city) which is 40 miles away and there are lots of problems."

And from another - The cost of inhouse surgery in 1986 was 1.7 million. In 1987 surgery was closed and patients sent to a local community hospital at a contract cost of $10,000 a case. Our Fiscal Officer estimated that the cost of surgical care for 1987 was 2.3 million or more than $600,000 in excess, without in-house surgery."

And one more, to us the most inspirational of all. "It would completely alter the practice of medicine if you do not have a Surgical Service. You would lose your medical staff. It is impractical to move the patients, and the quality of care will decline. It is very unfair to veterans. There was a recommendation to close our Surgical Service from the District, but it was reversed by Central Office!"

After careful consideration of all these materials, the Chiefs of Medical Services' Committee prepared and submitted to the Regionalization Committee a detailed complete consensus report of their findings. Time does not permit a review of this report, but it clearly supports the retention of Surgical Services in Dublin. Following is an excerpt: "We believe that it is our professional duty to state the consequences as we see them and others have experienced it. In the practice of medicine, the Surgical colleague is indispensable as a consultant in various surgical disorders much in the same way that the internists, cardiologists, etc., are indispensable members of the Surgical Service for the same reason. While there are services that have survived without much in the way of surgical input, they are the less for it, and all the Chiefs of Medicine in these circumstances agreed to it. In addition to his role as a consultant, the surgeon must be available as a backup for various diagnostic procedures like colonscopy, liver biopsy, kidney biopsy, and peritoneal dialysis. It is our belief that the removal of in-house surgical capability in Dublin, because of inadequate Surgical backup, would negatively impact upon the quality of medical care and impair their ability to attract the physicians necessary to run an acute Medical Service, and at the same time lead to reduced functions as patients would look for other medical resources."

This report was transmitted to the Regionalization Committee but it was apparently rejected or discounted severely.

Then let us take a close look at accessibility which was one of the criteria for an alternative procedure. The Surgical Review Team reported that bed space subject to contract was available at the Dublin HCA hospital and that local surgeons were available to provide the necessary service under contract. In this file is a letter from the Administrator stating categorically that he is not able to provide any type of surgical support and/or backup to our facility at present or in the foreseeable future. Similarly, there are only three general surgeons with privileges at this hospital. Two of them expressed complete disinterest in such an involvement, and the third would

consider it only at his convenience and after his other patients had exercised their priority. In summary and concerning accessibility to alternative surgical services in Dublin, there is absolutely none whatsoever.

Then we come to the third criteria which is cost. At this center the cost per day on our Surgical Service is $259.20 year to date as of June 30, 1988. This includes all services - Nursing, Surgery, medical consultations, Psychiatric and Psychology services, anesthesiology, Radiology, Laboratory, Pharmacy, Nuclear Medicine, Rehabilitation Service, Dietetic Service, Podiatry and Optometry service, Dental clinics, Prosthetic activity, the operating suite and surgical supplies.

We have a high regard for our local HCA Hospital, and we who can afford it, and thus are not eligible for VA hospital care are happy to have it available. In that hospital the basic bed rate is $186 per day. This does not include charges for the use of the surgical operating suite which are $73 per 15 minutes, unless you are classified as an emergency, for which the charge is $113 per 15 minutes. It does not include use of the recovery room and many of the operating room supplies. Beyond that it does not include charges for the Surgeon, Anesthesiology, Radiology, Laboratory, drugs, consultations for internal medicine, Psychiatry and Psychology, Physical Medicine Rehabilitation, Ophthalmology consultation and Optometry. Which bill would you prefer to pay?

We submit that the elimination of Surgical Service is clearly not working when it has been attempted, and will not work here, based on its own merits. It is therefore our concern that it may now be proposed as an element of a longer range plan of much broader consequence.

In one instance, in a discussion of diminished availability and access to surgical care, the Review Team noted in its minutes: "It was the considered opinion of the team that this issue was not a factor."

In another instance this statement appeared: "The Chairman noted that regardless of cost impacts, it is the committee's charge to recommend the viability to eliminate the unnecessary services and institutions for the better utilization of limited resources." We interpret this to signify that consideration is being given to the elimination of VA services and institutions no matter what it costs!

And finally, in discussing the facility mission of this Medical Center, this statement is listed: "If it is an intent for the mission to change to one of long term chronic care only, there is no need to maintain any surgical activity."

The loss of Surgical Service would initiate a clear path of regression. Next would be loss of acute Medical Service,

inability to recruit quality internists for only a chronic care facility, and the dominos would continue to roll. There was a time when we had old soldiers homes.

Our position is that this is undesirable, unnecessary, and contra indicated. Our appeal is to Central Office to plug up this hole in the dike, and set us about our business of caring for veterans.

We express our appreciation to the distinguished members of this committee for the opportunity to be heard, and for your unfailing support which is needed now more than ever before during the critical days ahead.

STATEMENT OF DAN ELROD

GENTLEMEN:

RESPECTFULLY, I WOULD LIKE TO THANK THE COMMITTEE FOR THE OPPORTUNITY TO ADDRESS THIS ISSUE. WE AT CARL VINSON VA MEDICAL CENTER AT DUBLIN, GA., HAVE MET AND DISCUSSED THE ISSUES UNTIL WE SINCERELY BELIEVE OUR CONCLUSIONS ARE VALID AND YOU WILL UNDERSTAND OUR POSITON.

WE HAVE SUBMITTED TO THE DISTRICT REGIONALIZATION COMMITTEE OUR RESPONSE TO THE REPORT PREPARED BY AN AD HOC TASK FORCE. I WANT TO SUMMARIZE OUR POSITON AS BEST AS I CAN, IN A WAY THAT DEMONSTRATES OUR HONEST BELIEF THAT THE AD HOC TASK FORCE RECOMMENDATIONS ARE NOT IN THE BEST INTEREST OF VETERANS, OUR STAFF AT THE CARL VINSON VA MEDICAL CENTER, MEDICAL DISTRICT 9, REGION 3, OR THIS COMMUNITY, OR THE VA BUDGET.

OUR OBJECTIVE IS TO PROVIDE QUALITY MEDICAL CARE TO OUR VETERANS. THE POTENTIAL COMPROMISES IN QUALITY OF CARE IN THE EVENT IN-HOUSE SURGERY IS NOT IN OPERATION WILL AFFECT US IN THREE PARTICULAR AREAS THAT I WILL ALLUDE TO:

1. THERE ARE NO LOCAL HOSPITAL CAPABILITES INTERESTED IN PROVIDING VETERAN CARE. THERE IS NO HOSPITAL READILY AVAILABLE TO PROVIDE SUPPORTS SERVICE FOR THE CARE OF OUR VETERANS. DUBLIN IS A RURAL AREA WITH A HOSPITAL CORPORATION OF AMERICA OPERATED FACILITY. THIS HOSPITAL DOES HAVE A SURGICAL SERVICE BUT THEIR MANAGEMENT IS NOT INTERESTED IN HAVING OUR WORK LOAD

SCHEDULED THERE. OF THE FOUR SURGEONS SUPPORTING THE HOSPITAL, ONLY ONE IS WILLING TO PERFORM ANY SURGERY FOR THE CARL VINSON VA MEDICAL CENTER, AND THEN ONLY IF IT IS A CATASTROPHIC EMERGENCY AND DOES NOT INTERFERE WITH HIS OWN CASE LOAD. IT IS DIFFICULT TO CONCEIVE THAT THIS HOSPITAL AND ITS LIMITED RESOURCES COULD BECOME A MEANS OF PROVIDING SURGICAL SERVICES TO THE 110,000 VETERANS IN DUBLIN'S 52-COUNTY PRIMARY SERVICE AREA. IN THE UNLIKELY EVENT AN ARRANGEMENT COULD POSSIBLY BE ESTABLISHED BETWEEN THE VA, THE LOCAL SURGEONS, AND THE HOSPITAL, ADDITIONAL AGREEMENTS WOULD THEN HAVE TO BE FINALIZED FOR THE NECESSARY ANCILLARY SERVICES, SUCH AS ANESTHESIOLOGY, PATHOLOGY, AND RADIOLOGY. THESE FIVE MAJOR CONTRACTURAL AGREEMENTS MUST BE COORDINATED WITH EACH OTHER. THIS SEEMS SO BURDENSOME, THAT THE CONCEPT IS REMOTE. THE AD HOC TASK FORCE STATED THAT A LOCAL SURGICAL CAPABILITY MUST BE AVAILABLE. THIS REQUIREMENT CAN NOT BE MET BY ABOLISHMENT OF THE IN-PATIENT SURGERY AT THE CARL VINSON VA MEDICAL CENTER. IN A RURAL MEDICAL ENVIRONMENT, STABILITY IS MANDATORY TO ASSURE AVAILABILITY OF HEAVILY RECRUITED MEDICAL SPECIALISTS SO THAT ALL NECESSARY SERVICES ARE PRESENT SO AS TO ASSURE QUALITY HEALTH CARE. PLEASE REMEMBER, GENTLEMEN, THERE IS NO LOCAL SURGICAL FACILITY OR SURGEONS THAT COULD BE SUBSTITUTED FOR OUR IN-PATIENT SURGICAL SERVICE.

THE AD HOC TASK FORCE SUGGESTS THAT AUGUSTA MAY BE AN ACCEPTABLE ALTERNATIVE. GENTLEMEN, AUGUSTA IS 98 MILES AWAY - ON A TWO LANE ROAD THAT IS HEAVILY TRAVELED, POPULATED WITH SEVERAL SMALL TOWNS. THE CONSERVATIVE ESTIMATE OF ONE-WAY TRAVEL TIME IS 2 1/2 HOURS.

HOWEVER, BEFORE TRAVEL COULD BEGIN, THERE WOULD BE A WAITING TIME TO CALL OUR STAFF, ARRANGE FOR A VEHICLE AND PROVIDE AN ATTENDANT, IF NEEDED, FOR THE VETERAN. THE PATIENT WOULD THEN HAVE TO WAIT FOR AN UNDETERMINED LENGTH OF TIME IN AUGUSTA BEFORE BEGINNING HIS TRIAGE THERE. WE KNOW WHAT KIND OF SERVICE AND PRIORITY TO EXPECT. THE PATIENT WOULD THEN EITHER BE ADMITTED OR RETURNED TO US. THE NUMBER OF PATIENTS WE WOULD HAVE TO SEND TO AUGUSTA JUST FOR CONSULTATIONS AND SURGICAL ASSESSMENTS WOULD MAKE THIS ARRANGEMENT IMPRACTICAL. OVER 780 URGENT CONSULTATIONS CAN BE EXPECTED EACH YEAR. THE PATIENT AND HIS FAMILY WOULD BE TRAUMATIZED WITH THIS ARRANGEMENT AND THE TRAVEL TIME AND COST WOULD GO UP DRAMATICALLY AND UNNECESSARILY. WE ALSO WOULD LIKE TO QUESTION AUGUSTA'S ABILITY TO ACCOMODATE INCREASED WORKLOAD WITH THEIR PRESENT STAFF.

2. LOSS OF OUR IN-PATIENT SURGERY WOULD MOST ASSUREDLY DECREASE OUR CAPABILITY TO CONTINUE OUR HIGH QUALITY OF ACUTE MEDICAL CARE. THE DIRECTOR OF MEDICINE IN VA CENTRAL OFFICE, MEDICAL DISTRICT 9 MEDICAL SERVICE COMMITTEE AND AN ASSESSMENT OF HISTORICAL RESULTS FOR SIMILIAR MOVES, ALL CLEARLY POINT TO THE ADVISABILITY OF KEEPING OUR IN-PATIENT SURGERY CAPABILITY. THE FINE RESULTS WE OBTAIN THROUGH TREATING PATIENTS ON OUR ACUTE MEDICINE WARDS COULD BE NEGATIVELY AFFECTED, IF WE PHYSICIANS DID NOT HAVE THE SURGICAL BACKUP REQUIRED. OUR SURGEONS PROVIDE SURGICAL ASSESMENTS TO MEDICAL PATIENTS SO AS TO WORK OUT THE MOST BENEFICIAL TREATMENT PLAN. WITHOUT THIS SURGICAL PRESENCE, THE TREATMENT PLANS WOULD HAVE TO BE MODIFIED, SINCE SURGICAL

OPTIONS WOULD BE ELIMINATED. LENGTHS OF STAY WILL INCREASE. AGAIN, THE BIG LOSER WOULD BE OUR VETERANS.

ANOTHER UNAVOIDABLE REPERCUSSION IS THE STRONGLY NEGATIVE IMPACT THAT LOSING IN-PATIENT SURGERY WOULD HAVE ON THE MEDICAL AND SURGICAL STAFF. WE HAVE EXCELLENT BOARD CERTIFIED PHYSICIANS THAT WOULD SEE THEIR EXPERTISE ATROPHY AND THE TREATMENT OPTIONS BECOMING INCREASINGLY RESTRICTIVE. WHAT KIND OF MEDICAL STAFF WOULD BE CONTENT TO SEE THEIR SPECIALITIES NO LONGER USED? WHAT KIND OF SURGICAL STAFF WOULD BE CONTENT TO RESTRICT THEIR PRACTICE TO OUTPATIENT SURGERY ONLY? THE QUALITY OF OUR MEDICAL STAFF HAS A DIRECT IMPACT UPON OUR ABILITY TO PROVIDE QUALITY OF CARE.

3. DUBLIN IS NOT AFFLIATED WITH A MAJOR MEDICAL SCHOOL AND DOES NOT HAVE A GREAT WEALTH OF MEDICAL FACILITIES READILY AVAILABLE. THE OTHER VA HOSPITALS IN OUR DISTRICT HAVE ACTIVE AFFILIATIONS AND HAVE SEVERAL HOSPITALS WITHIN THEIR METRO CITY LIMITS FROM WHICH TO SHARE RESOURCES. DUBLIN HAS NONE OF THIS. THE LACK OF PUBLIC TRANSPORTATION AND THE LARGE GEOGRAPHIC DISTRIBUTION OF PATIENTS MUST BE CONSIDERED. ONE OF THE MAJOR CONCERNS THE REGIONALIZATION COMMITTEE FIRST IDENTIFIED WAS A COMPARATIVELY HIGH PERCENTAGE OF OUR INPATIENT SURGERY THAT APPEARED TO BE THE KIND OF SURGERY THAT COULD BE DONE ON AN OUTPATIENT BASIS. WHAT MUST BE CONSIDERED IN THIS LIMITED ANALYSIS IS THE FACT THAT OUR PATIENTS HAVE A MUCH LONGER DISTANCE TO TRAVEL WITH NO FORMAL LOCAL TRAVEL SYSTEM. CONSEQUENTLY, THIS NARROWS THE AMOUNT OF

DISCHARGED THE DAY AFTER THEIR SURGERY. ANTOHER FACTOR IS THE TOTAL LACK OF PUBLIC TRANSPORTATION, WHICH REQUIRES OUR PATIENTS TO COORDINATE THEIR TRAVEL NEEDS WITH THEIR FAMILY. ETC. FAMILY MEMBERS WHO WORK MUST ARRANGE FOR SUBSTANTIAL TIME OFF FOR EVERY TRIP HERE. THE PROBLEM WOULD ONLY BE COMPOUNDED IF THEY WERE TRAVELING FARTHER DISTANCES TO AUGUSTA OR CHARLESTON. THIS HOSPITAL HAS ALWAYS ATTEMPTED TO STAY WITHIN ITS CAPABILITIES. WE ARE NOT MEETING HERE TODAY BECAUSE DUBLIN IS TRYING TO EXPAND ITS SURGICAL CAPABILITIES. WE ARE OPERATING AS A REFERRAL FACILITY AND HAVE SENT MANY WEIGHTED WORK UNITS TO AUGUSTA THAT MIGHT OTHERWISE HAVE BEEN DONE AT THE VAMC, DUBLIN, GA. WITH ADEQUATE RESOURCES. THE SURGERY THAT WE DO IN DUBLIN IS WELL WITHIN OUR CAPABILITIES. MUCH OF OUR SURGICAL RESOURCES RESULT IN REFERRAL TO MEDICAL DISTRICT 9 HOSPITALS. TAKE AWAY OUR INPATIENT SURGICAL RESOURCES AND THERE WILL BE AN OVERALL NEGATIVE IMPACT ON WORKLOAD CURRENTLY ATTRIBUTED TO MEDICAL DISTRICT 9. VETERANS ON OUR FRINGE AREA WILL EITHER GO TO OTHER DISTRICTS OR UNFORTUNATELY, THERE WILL BE THOSE PATIENTS WHO WILL NOT GET QUALITY CARE IN A TIMELY MANNER.

FINALLY, THE COST ASSOCIATED WITH MAINTAINING A SURGICAL CAPABILITY THAT WILL MEET THE CURRENT ESTABLISHED SURGICAL WORKLOAD IS ESTIMATED TO BE AT NO ADDITIONAL COST. I HAVE DISCUSSED WITH OUR FISCAL OFFICER AND OUR ASSOCIATE DIRECTOR AND HAVE BEEN ASSURED THAT ALREADY ADJUSTMENTS OF MONIES HAVE BEEN MADE THAT WILL RESULT IN A SAVING OF APPROXIMATELY $435,000.00 IN OUR SURGICAL DEPARTMENT. AS A RESULT OF THESE CHANGES, CARL TIME PER DAY THAT WE CAN SUCCESSFULLY RUN AND SCHEDULE OUR OUTPATIENT SURGICAL WORKLOAD. NOT WASTING THE REST OF THE AVAILBLE O.R. TIME RESULTS IN ADMISSIONS FOR SURGERY FOR THOSE WHO MUST (BECAUSE OF DISTANCE) BE ADMITTED THE DAY PRIOR OR

VINSON VA MEDICAL CENTER INPATIENT SURGERY SERVICE COULD CONTINUE AT THE SAME COST AS THE RECOMMENDED LEVEL OF OPERATION. THE ESTIMATE OF ADDED COST FOR BOTH TRAVEL WITH NEEDED ATTENDANTS FOR THE PRESENT CASELOADS AND FEE BASIS OUT TO THE COMMUNITY, IF SERVICES ARE AVAILABLE, IS CONSERVATIVELY ESTIMATED AT AROUND $500,000. THIS $500,000 WHEN CONSIDERING THE SAVINGS THAT WE HAVE ALREADY GARNERED MEANS THAT CLOSING OF THE INPATIENT SURGERY PROGRAM WOULD SAVE NO MONEY AND COULD BE MORE THAN OUR SURGICAL COSTS ARE AT PRESENT. EVIDENTLY, TO IMPLEMENT THE AD HOC TASK FORCE RECOMMENDATION, DUBLIN WILL HAVE MAJOR OPERATING ROOMS FULLY EQUIPED STANDING IDLE. OUR EQUIPMENT IS IN GOOD SHAPE BUT NOT THE CALIBER FOR REDISTRIBUTION. THERE IS ALSO AN ASSUMPTION THAT QUALITY OF CARE WILL NOT SUFFER. YET THIS IS FAR FROM WHAT IS PROFESSIONALLY EXPECTED OR CAN BE HISTORICALLY SHOWN.

IN CLOSING, I WOULD LIKE EVERY DECISION MAKER TO PLEASE REMEMBER: (1) THE LOCAL HOSPITAL ADMINISTRATOR SAYS HIS FACILITY IS NOT AVAILABLE. (2) THE LOCAL SURGEONS SAY THAT THEY ARE NOT AVAILABLE. AND (3) THRU INCREASE TRAVEL, AND WASTED TIME, QUALITY OF CARE WILL BE COMPROMISED. IT WILL BE MORE COSTLY TO PROVIDE LESS. THANK YOU.

DAN B. ELROD, M.D.
DECEMBER 2, 1988

STATEMENT OF JANICE BUCHANAN

SUMMARY FROM CHIEF, NURSING SERVICE
PRESENTED FOR THE CONGRESSIONAL HEARING
CARL VINSON VETERANS ADMINISTRATION MEDICAL CENTER
DUBLIN, GEORGIA

DECEMBER 2, 1988

Nursing Service appreciates the opportunity to address the Subcommittee on our experiences and views regarding the impact of diminishing budgetary resources on the delivery of health/nursing care at this facility to the veterans in our primary service area. We endorse fiscal prudence and the concept that all must strive diligently to find better more efficient ways of doing things to the point that this can be accomplished without compromising the quality of the delivery of care.

The nursing ceiling of 288.9 FTEE is distributed to support 14 wards (3 EHC, 3 Medical, 1 Surgical, 1 RCU, 1 ICU, 3 NHCU, and 2 Psychiatric), four special services (Ambulatory Care, Hemodialysis, Operating Room, and Domiciliary Clinic), administrative and educational guidance of the staff. The ceiling of 288.9 represents a loss of six FTEE in August 1988 to accommodate the medical center's continued downward adjustment of FTEE.

I

SURGICAL PROGRAM

Recognize that the proposal to discontinue the surgical service at VAMC, Dublin, Georgia, is an outgrowth of diminishing resources and is only in the planning/review stage at the present time. From a nursing perspective, the closure of this service would impact negatively on the quality, accessibility of care and the mission of the facility to provide quality care to the veterans of this rural area. Additionally, would not serve to generate dollars to be more effectively used through the process of regionalization.

A. Quality of Care - The Impact Would Be Negative:

Quality of care offered at this station is not in question;

Cost of providing that care is documented to be equal to or less than average within the District;

Registered nurse staff, operating room, surgical floor, is among our most experienced and stable staff. All RNs in OR have national certification. The Supervisor, MSN, was Supervisor of operating room at Medical Center of Middle Georgia prior to this appointment. On the surgical floor, the staff are experienced surgical nurses - three have

national certification;

This qualified staff would seek positions in other surgical settings if this service closed. This would be a loss to the VA system;

The patient transfer process would interrupt continuity of care to the patient and impact negatively a readiness for successful discharge planning;

Many hidden costs, which do not currently exist, to be covered with diminished resources, i.e., duplication of medical work-up, transportation costs;

Delays in surgical consultations;

Patient and his family would be separated; family could not participate in supportive role - would not be available to be taught of patient's health care needs;

No immediately available emergent transporation, which could be life threatening in select instances.

B. Assessability of Care - This Would Impact Negatively On The Clientele.

Demographic location - primary service area is rural;

There is an absence of other rural health care systems, especially to support the economically deprived (a significant segment of our clientele);

Family transportation often inadequate; absence of public transportation. If transportation happens to be available driver not accustomed to metroplex driving;

Provision of transportation by facility is costly (Approximately $325.00 a trip), time consuming (often takes hours for nursing supervisor to find nurse accompaniment);

Trip is lengthy, 2-plus hours one way over rural road system. Very difficult on elderly,fragile of health, with multiple medical problems;

Early return, following surgical procedure, interrupts and fragments care, is physically stressful; family not available to be part of support system, destroys continuity of care.

Regionalization has not proved to be an effective approach to quality of care or cost reduction for state or private health care services. The rural clientele of this PSA are deserving of a full service medical center offering quality care. In view of

accessability problems, the redirection of this surgical service regionally would serve to reduce quality care and would not generate increased dollars for care due to hidden costs involved in bringing the patient and the surgical service together, to say nothing of the negative impact of delayed intervention.

Nursing requests your indepth consideration to keep intact a full service medical center that is delivering quality care and effectively serving the health care needs of this rural setting in a cost-effective manner.

II

NURSING SHORTAGE

During the past 12-month period, Nursing has continued to provide a safe level of care in all existing wards, has continued all programs of care, additionally has opened a new pschiatric ward, and has not closed beds or services. This accomplishment has not, however, been without stress, frustrations and concerns for our ability to continue this accomplishment due to the impact of budgetary constraints. The greatest challenge has been non -competitive registered nurse salaries which led to a nurse shortage at this facility. In March of 1988 the Medical Center of Central Georgia raised their salaries for registered nurses up to 24 percent. This was quickly followed by similar raises in all health facilities in Macon, Milledgeville, Dublin and other surrounding communities. In response, nurses from our facility were attracted by increased dollars. We have documented records of staff with extensive years or specialized experience resigning from salaries of approximately $12.00 an hour to accept a salary of $18.00 to $23.00 an hour. We attracted no new graduates in June 1988 because we were non-competitive on salary dollars. Recently we have also begun to note acceleration of the LPN salary in our local area. Registered nurse FTEE, during this 12-month period, fell from a high of approximately 131 FTEE to a low of 110 FTEE, and now stands at 122.8 FTEE. (RN ceiling, with new psychiatric service added, now 142.9). We have also not been able to recruit up to our LPN ceiling. Current LPN deficit - 6 FTEE. The coping mechanisims used included:

Rotation of RNs from long-term care areas to acute care to provide coverage of one RN around the clock;
Increased role of LPN in medication administration;

Piloted centralization of select RN functions (IV Nurses);

Adjustment of staff mix;

In the process of expanding the role of the LPN;

Implemented compressed work week, including introduction of 24-hour weekend (part-time);

Computerized select functions - Nursing Care Plan, Assignment Sheet;

Accelerated nurse recruitment activities, media visibility;

Used overtime and interservice detailing to fill unplanned staffing emergent needs;

Submitted data and request to Central Office for special salary rates with accompanying funds;

Employment of less skilled staff (temporary) with selective placement.

We have carefully monitored to assure a safe level of care within this period of nurse shortage. It is, however, very evident that short-term emergent substitutes to meet the nursing shortage created by non-competitive salaries will not support the giving of quality care on a long-range continium.

Mr. Chairman, adequate salary dollars are needed to support a competitive salary range for registered nurses in order to preserve the standard of quality care for veterans.

Janice Buchanan

JANICE BUCHANAN, RN
Chief, Nursing Service

CARL VINSON VA MEDICAL CENTER

Testimony by Dr. A. C. Pradhan

Chief, Medical Service

I would like to thank the committee for this opportunity.

On June 23, 1988, a Medical District Surgical Ad Hoc Task Force met at Carl Vinson VA Medical Center, Dublin, Georgia. They recommended that the inpatient Surgical Service be closed.

Effect of this plan on our patient care would be tragic. Let me state categorically that all medical staff physicians and dentists alike, feel it would adversely affect quality of care, suppress medical demand and unfortunately some seriously ill patients could die without receiving proper care. Let me state this at outset that our jobs are not at stake, what is at stake is quality of care.

We have reviewed the discussion in the Regionalization Committee Minutes of August 30, 1988. Minutes state Review Team recommendations would be accomplished with following conditions satisfied:

(1) The first requirement is formal agreement between Carl Vinson VAMC and Augusta VAMC. We all know many difficulties we experience with specialty care, e.g., Orthopedics.

Consider this hardship, extra two hundred mile travel for a weak and feeble patient.

Task Force defines a catastrophic emergency as one requiring surgery within 1-2 hours, while they differentiate urgent care as the one requiring surgery in the next 4-6 hours; while no mention is made of what happens between 2-4 hours. No one has such "crystal ball" vision and this would never work in reality.

2.

I would like to draw your attention to the expressed opinion of all Chiefs of Medical Service in our District, "The transfer of patients from one facility to another irrespective of how fast the helicopter or ambulance can go, requires extended periods of time because mobilization of transport, transport itself, re-evaluation by receiving team and special diagnostic procedures done in receiving institution."

(2) Now, second requirement is a formal agreement between Fairview Hospital and appropriate community services with VA. This is not practical, as stated by Fairview Administrator!

Next, is a formal agreement between one local surgeon and Carl Vinson VAMC. This is ridiculous, knowing the fact we have 110,000 veterans in our service area, our Surgery performed 2,473 cases last year and responded to 7,718 consultations, with at least 800 emergent nature consultations. Remember, two community surgeons have stated they are not interested. Third surgeon has stated his private patients would be his priority.

(3) Third requirement is presence of viable dialysis program. All Nephrologists agree that loss of Surgery would adversely affect our ability to provide acute dialysis services.

(4) Next requirement is, there would be no significant detrimental effect on acute medicine.

We have clearly shown that loss of inhouse surgery will adversely affect quality of care. This has been the experience and opinion of Chiefs of Medical Service where Surgery has been closed. This is the expressed opinion of all Chiefs of Medical Service in our District. It clearly states, "Removal of inhouse surgical capability

3.

in Dublin because of inadequate surgical back-up, would negatively impact on quality of medical care and impair their ability to attract the physicians necessary to run an Acute Medical Service." It further states, "The absence of inhouse surgery capability seems to expecially limit requirement of subspecialist whose invasive procedures require surgical back-up."

We know by year 2000, two out of three males over the age of 65 years will be veterans. With aging we face many problems including urological problems. We are fortunate enough, to be able to provide these essential services with a board-certified Urologist on the staff. Remember, no competent Urologist including ours will stay on the staff performing only outpatient Urology.

Experiment of outpatient Surgery will not succeed due to our rural setting. We will not be able to retain a well qualified Surgeon, Urologist, Anesthesiologist, or Podiatrist as proposed without inhouse Surgery.

Remember, a consultation from a retired Surgeon, who cannot perform any surgery is worse than having no surgical opinion at all. Please tell us, how many of you would want to go to a Surgeon, who has lost his skills?

We are providing excellent quality of care with inhouse Surgery. Without Surgery, our ability to treat critically ill patients would be severely restricted.

Loss of inhouse Surgery means loss of emergency readiness. This Carl Vinson Medical Center will deteriorate to a Nursing Home facility, unable to fulfill its mission of acute medical and surgical care.

4.

I was able to attract many subspecialists providing excellent medical care; all of them would consider alternatives with eventual loss of these services to our patients.

I had the opportunity to discuss with many Chiefs of Medical Service, who are serving our rural population. Sir, we all hope erosion of medical care for our veterans in rural communities will not be continued. Unfortunately, with shrinking resources, glamorous metropolitan hospitals get the attention and needs of rural population may be forgotten. We do not perform rare and glamorous surgery, that benefits few but attracts the spotlight!

We take pride in our mission and provide quality care with cost effective manner. I urge you Sir, to help us retain quality care for our veterans in rural population.

Thank you for your valuable time!

STATEMENT OF PETE WHEELER

Mr. Chairman and Members of the Committee --

My name is Pete Wheeler.
I am Georgia's Commissioner of Veterans Affairs.

We are very proud of our three veterans Medical Centers in Georgia which are located in Atlanta, Augusta and here in Dublin. I have had the honor of working for Georgia veterans and their dependents for over 40 years and have known each of the VA Hospital Directors during that time. We now have the three most outstanding hospital directors we have had during that time. Mr. Glenn Alred - Atlanta, Mr. Don Burnette - Augusta and Mr. Bill Edgar here in Dublin. They are the most dedicated hospital directors I have ever known. We appreciate them very much.

We are here this morning to discuss the impact of the VA

budget situation on the delivery of health care to veterans living in rural areas and to make recommendations regarding the Dublin VA Medical Center. We oppose the elimination of the inpatient surgical unit here at the Dublin VAMC. This would be a drastic measure - in the battle for economy in the VA's medical system.

Relegating veterans in need of surgery to lengthy travels to other VA medical centers in Atlanta, Augusta or perhaps Charleston, South Carolina would, in many instances, constitute unnecessary hardships on the veterans and their families.

And sending them to these other VA facilities would be the only alternative they would have. Surveys made in and around Dublin clearly indicate that there would be no dependable surgical back-up from the private sectors. Area physicians have stated that their private citizen patients will have priority, and rightly so. These doctors added that they definitely would not make themselves available to the Dublin VA Medical Center on an "on call" basis for any type of surgery, be it routine or emergency.

Closing the surgical unit here at Dublin would be denying veterans in the central and southern area of Georgia, with a population of 110,000, a branch of medical service which they deserve and one which should be available.

There is no doubt in my mind that closing the surgical unit will result in a deterioration in the overall quality of care at the Dublin VA Medical Center. A hospital without surgical capabilities is not really a hospital.

We fail to see where any monetary savings would be realized with the closing of Dublin's surgical unit. Transporting veterans in need of surgery to other VA facilities would be very costly, indeed. With no possibilities of surgery being available locally on a contract basis, a multitude of travel would be the only answer.

There is serious doubt that surgical needs of veterans could be met in the area served by the Dublin VA Medical Center should the surgical unit be removed. There is a 191-bed hospital in Dublin which has only three general surgeons and one anesthesiologist serving not only Laurens County, but several neighboring counties as well. In Laurens County alone, the surgeon/patient ratio is approximately 1 to 9,000.

The Carl Vinson VA Medical Center serves as a provider of primary care, secondary care, nursing care and domiciliary care.

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Certainly, this issue concerning surgery is much too important to the veterans who come to this facility for a decision to be made based on assumptions rather than on facts derived from a detailed study.

It is our contention that the elimination of surgical beds at this medical center would have a profound detrimental effect on the quality of patient care provided by the Carl Vinson VA Medical Center.

Information received in our Georgia Department of Veterans Service offices indicates that the recommendation for eliminating surgical procedures at the Dublin VA Medical Center came from a committee who visited the Dublin VA Medical Center for only one-and-a-half days. I find it difficult to comprehend how such a determination to close a surgery unit (or any other service, for that matter) could be made with what amounted to only a brief examination of the facility. A day and a half - a mere twelve hours, is not much time to devote to a study, the results of which could be potentially devastating to so many people.

We understand that the Veterans Administration is faced

with a shortfall of some $817 million for Fiscal Year 1989. With amounts such as this - approaching the billion-dollar mark conditions facing the VA's health care system can only get worse.

The bottom line is every dollar denied the VA's budget means that America's veterans will be denied another dollar's worth of VA services or benefits.

Georgia is geographically the largest state east of the Mississippi River. The state is primarily rural with only a few of its 159 counties considered to be metropolitan.

There are some 653,000 veterans living in Georgia. Approximately 52 percent of these veterans reside in ten metropolitan counties while the remaining 48 percent live in rural counties which are generally classified as being medically under served.

During the past five years, 63,642 veterans, or about 62.6 percent of the total number of veterans discharged from VA Medical Centers in Atlanta, Augusta and Dublin, came from rural Georgia counties; there were 39,967 metropolitan area veterans discharged from these three VA medical centers during that same time.

Veterans residing in rural areas of Georgia utilize VA

medical care services at a much higher rate than those residing in metropolitan areas primarily because of rural areas being medically under served.

Total discharges from VA Medical Centers in Atlanta, Augusta and Dublin for veterans residing in the State of Georgia virtually remained the same in Fiscal Years 1987 and 1988 (20,679 and 20,614 respectively).

In Fiscal Year 1987 alone, 61.5 percent of the discharges from VA Medical Centers in Atlanta, Augusta and Dublin were veterans residing in rural areas of Georgia (12,723). In Fiscal Year 1988, 60.6 percent of the discharges from VA Medical Centers Atlanta, Augusta and Dublin were veterans residing in rural areas of Georgia. This represents a one percent decrease as a share of the total discharges.

During the period Fiscal Year 1984 through Fiscal Year 1988, outpatient visits at Atlanta, Augusta and Dublin VA Medical Centers for veterans residing in the State of Georgia have increased 38.4 percent (194,940 visits to 269,852 visits). This increase is primarily due to the emphasis of outpatient care as an alternative to more costly inpatient care.

Over the five year period, 46.5 percent of these outpatient visits have come from veterans living in rural counties while 53.5 percent of the visits have come from

veterans residing in metropolitan counties.

Total outpatient visits increased from 261,047 to 269,852 between Fiscal Year 1987 and Fiscal Year 1988.

The Veterans Administration is mandated by Congress to operate 90,000 beds throughout the VA's medical system. Current figures indicate that more than 13,000 of this authorized figure are not in service.

A graphic example of this situation may be found in the Atlanta VA Medical Center where there are 550 authorized beds; 95 beds are empty.

The reasons given for these operating beds being out of service include shortages of personnel including physicians, registered nurses, respiratory therapists, radiology technicians, pharmacists, physical therapists and occupational therapists.

Over the years, proposed cuts in budgets for the Veterans Administration and the resulting short falls in funding for various benefits and services to veterans have come upon the scene with regularity.

The latest, and, indeed quite sizeable proposed reduction

comes at a time when many services to veterans already are at severe low points across the nation.

For example, consider the funding lost to "Productivity Improvement" at the three VA Medical Centers in Georgia between Fiscal Year '85 and Fiscal Year '88; "Productivity Improvement" is a one percent reduction of resources imposed by the Office of Management and Budget as part of the Gramm-Rudman Act. The Vinson VA Medical Center in Dublin had its funding reduced by $529,523; the Augusta VA Medical Center was cut by $1,414,867 and the VA Medical Center in Atlanta had its funding reduced by $1,014,941.

Recently your Committee on Hospitals and Health Care and the Senate Veterans Affairs Committee held oversight hearings to look into the status of operating funds for the VA's Department of Medicine and Surgery.

Your Committee concluded that fiscal health of the VA's medical system is not good. Your survey found that each VA hospital, on the average, has had to absorb $1.4 million in unfunded operating requirements thus far in Fiscal Year 1988. According to the survey, hospital directors are being forced to juggle resources and are raiding equipment, drug, medical supply, maintenance and other accounts in order to meet daily operating requirements. Inadequate funding has resulted in a barrier to competition with the private sector for health care

beds and less health care delivered to eligible veterans.

Current estimates suggest the Fiscal Year 1989 shortfall for the Department of Medicine and Surgery is in excess of $800 million. Unless a supplemental appropriation is provided for Fiscal Year 1989 there is every likelihood that further health care reductions will occur.

Decreases in budgeting have had an adverse effect on patient care and will continue to erode the quality, quantity and timeliness of health care services provided the veteran beneficiaries.

Clearly, administrative and medical staffs alike have suffered budget cuts resulting in seriously inadequate resources to maintain the same high quality level of service and treatment our veterans deserve. So far, the VA's medical system has done a remarkable job of serving our veterans. The staffs of VA medical facilities deserve high praise for their delivery of VA health care.

I have highest praise and the most profound respect for hospital directors Glenn Alred in Atlanta, William Edgar in Dublin and Don Burnette in Augusta. They and their staffs have managed to keep veterans health care solvent in recent years.

In all candor, though, I feel that the practice of trying

to do as much or more with less has a breaking point that we have about reached.

Assuming that during Fiscal Year '89, workloads at VA Medical Centers in Atlanta, Augusta, and Dublin remain the same as in Fiscal Year '88; that funding remains as shown on the Fiscal Year '89 Target Allowance; that all assigned positions are fully supported in Fiscal Year '89, that each facility implements all mandatory aspects of P.L. 100-322, and that all control point requests are reduced to the minimum level possible, it is estimated that shortfalls in Fiscal Year '89 will amount to $5,000,000 at VA Medical Center Atlanta; $1,831,986 at VA Medical Center Augusta and $814,860 at VA Medical Center Dublin.

These shortfalls will have a serious detrimental effect on the workloads at these three VA Medical facilities. The Atlanta VA Medical Center workload will be reduced by 362 inpatients and 5,362 outpatient visits; 268 fewer inpatients and 12,000 fewer outpatients will be the story at the VA Medical Center in Augusta, and Dublin will have a reduction of 568 patients. The total impact on workloads at Atlanta, Augusta and Dublin will be that 18,560 fewer patients will receive authorized medical attention.

In conclusion, I want to commend the Committee on Veterans Affairs Chairman G. V. (Sonny) Montgomery and the members of yours Committee for looking after the interest of the nation's sick and disabled veterans. I particularly want to commend the Honorable J. Roy Rowland and the members of your committee for taking the time to come here today to seek ways to help our sick and disabled veterans. We hope the information we have given you has been of some benefit to you.

Mr. Chairman, Members of the Subcommittee, and Distinguished Guests:

UNIT DOSE MEDICATION MANAGEMENT PROGRAM

A. DEFINITION

A unit dose medication management system may be defined as a system whereby all medication doses are dispensed by the Pharmacy pursuant to a physician's orders to individual patients, in ready to administer form. The doses are identifiable up to the point of final administration. An I.V. Additive System can be considered as a specialized Unit Dose System in that all I.V. solutions are prepared by the Pharmacy for individual patients.

B. BACKGROUND

In September 1975, the GAO published a report "Potentially Dangerous Drugs Missing in VA Hospitals - Different Pharmacy System Needed". The review showed that substantial drug losses were occurring in VA Hospitals using the traditional ward stock system. The GAO recommended that the VA convert all their ward stock hospitals to the unit dose system. At the time of this study, only 4% (7) of VA Hospitals had a unit dose system. (To date, approximately 70% of all VA Hospitals have been converted to unit dose.)

Even though the main purpose of this study was to determine drug accountability, the GAO concluded that the unit dose system could:

1. Improve patient safety by reducing medication errors through pharmacist review of individual medication orders.
2. Reduce nursing time devoted to medication-related activity and provide more direct patient care.
3. Improve control over drugs leaving the Pharmacy.
4. Reduce drug pilferage from patient care areas.
5. Reduce drug inventories throughout the hospital.

The GAO did point out that the primary disadvantage of the unit dose drug system is that Pharmacy costs increase because:

1. Unit dose packaging requires more space than bulk packaging.
2. More equipment is needed to distribute medications to patient care areas.
3. More Pharmacy staff is needed.
4. Unit dose drug packaging may cost more than drugs purchased in bulk.

Traditionally, Nursing has interpreted the physician's orders, intervened with physicians for dosage and appropriateness under the ward-stock system, maintained an adequate drug inventory,

administered drugs, and performed many clerical activities associated with drug administration. Due to the administrative aspects of the ward-stock drug distribution system, Nursing has become heavily involved in drug preparation activities. Under unit dose medication management system, this is transferred back to Pharmacy where it rightly belongs. Therefore, it seems to make sense to place the pharmacist who has expertise and training in drug use control in the patient care area. In the unit dose system the pharmacy is responsible for all aspects of medications up to the point of administration. The nurse can then concentrate on administering the medicine, thus reducing the clerical work in addition to eliminating ordering, management of floor stock and preparation of patient medication.

In an earlier study (1972) the GAO had done a comparative analysis of all annual-cost elements in unit dose and traditional ward stock hospitals. The cost analysis showed that in unit dose hospitals with 400 or more beds, the life cycle savings were primarily attributed to reductions in nursing time spent preparing and administering medications. The study concluded the subjective benefits of unit dose systems may over-ride economic considerations regardless of quantifiable cost factors. Subjective benefits would include improved patient care due to more nursing time spent for direct patient related activities, improved patient safety through reduction in medication errors, and a closer relationship between physician, pharmacist, and nurse.

The basic advantages of the unit dose system over the archaic traditional ward stock system includes: Reduction in medication errors, decrease and/or elimination of pilferage, provides a more accurate financial accountability of drugs used and dispensed, increased control on narcotics, provides greater drug utilization review and quality assurance studies as a measure of compliance with given standards, increases the pharmacist's interaction with the physician, nurse, and patient, improves IV therapy and infection control standards by placing the preparation back to pharmacy, impacts on the efficient utilization of nursing time back to patient care, and decreased medication errors.

In 1977 the VA contracted with the Computer Science Foundation (CSF) to do a Unit Dose Benefit/Cost study. The CSF compared 5 unit dose hospitals to 5 ward stock hospitals.

In 1978 the Health Service Research and Development Service (HSR&D) published a "Summary of Findings and Recommendations on the Unit Dose Cost/Benefit Analysis". The study found a benefit/cost ratio of about 2:1 for the unit dose system as compared to the ward stock system. The study determined that converting the five ward stock hospitals to unit dose would have the following effect per hospital:

1. Reduction in the probability of medication errors from approximately 0.52 to 0.11 per patient day. The odds of a medication error per medication administration for various errors were as follows:

		Ward Stock	Unit-dose
a.	Dose Omitted	1 in 17	1 in 86
b.	Wrong Amount of Drug	1 in 27	1 in 250
c.	Extra Doses	1 in 77	1 in 286
d.	Unordered Drug Administered	1 in 34	1 in 333
e.	Drug Administered in Wrong Form or Route	1 in 166	1 in 1000
f.	Administered Outdated Drug	1 in 145	1 in 714
	Total a through f	1 in 7.4	1 in 41.7

2. Thirty per cent (30%) savings in nursing time devoted to medication activities (a cost-savings of about $360,000/year per hospital) which could be applied to other nursing patient care activities.

3. Increased control and accountability in medication distribution - resulting in a reduction in loss of medications from 33% to 14%, for a net medication savings of approximately $47,000 per year per hospital.

4. An increase in inpatient Pharmacy staff of 107%.

The HSR&D recommended that the majority of VA DM&S Hospitals should be converted to the unit dose drug distribution system and centralized I.V. additives program.

C. PRESENT MEDICATION MANAGEMENT AT DUBLIN VAMC AND ITS IMPACT ON THE HOSPITAL

The Dublin VAMC is the only VA in Medical District 9 without a major affiliation that does not have a unit dose drug distribution system. Twenty-nine of the thirty VA's in Southeastern Region 3 have been converted to unit dose. Dublin is the only hospital with no beds converted.

The lack of a unit dose drug distribution program at the Dublin VAMC has been documented by both JCAH and SERP. The following excerpt is taken from the last JCAH Survey:

"As twice previously reported, the pharmaceutical department/service should provide drug monitoring services that include:

a. a patient drug profile; and

b. a review of the patient's drug regimen for any potential interactions, interferences, or incompatibilities prior to dispensing drugs to the patients. (123, 124)

As three times previously reported, a pharmacist should review the prescriber's order or a direct copy thereof, before the initial dose of medication is dispensed. In cases where the pharmacist is unavailable when the order is written, the order should be reviewed by the pharmacist as soon thereafter as possible, preferably within 24 hours. It is noted that additional staffing for the pharmacy has been requested. (124)

It is again recommended that the unit dose drug distribution system, which permits identification of the drug up to the point of administration, be used throughout the hospital. It is noted that additional staffing has been requested. (consultative recommendation) (124)"

Nursing studies have demonstrated that at times over 60% of nursing time is needed to handle medications at the Dublin VAMC. Nurses exit interviews have attributed the lack of unit dose as a reason for leaving. Nursing schools teach their students in unit dose and I.V. admix systems. Therefore, the lack of these systems at the Dublin VAMC contributes to the recruitment problem of nurses and also to their retention.

The Pharmacy Service maintains the largest operating budget ($1,259,000 FY 88) with approximately 47% of this going to inpatient. Yet, the current ward stock system of drug distribution does not allow for Pharmacy intervention in the appropriateness of use of the drugs going to inpatients.

D. PROGRAM DESCRIPTION OF UNIT DOSE

The Pharmacy will provide 24 hour/day - 7 day/week coverage; I.V. additives preparation will be centrallized (I.V.'s prepared in the Pharmacy) and unit dose will for the most part be decentrallized (medications dispensed from supplies on the floor). The Pharmacy will utilize technical support to the fullest extent, with a ratio of approximately 1.5 technicians to 1 staff pharmacist. Pharmacist involvement in the inpatient medication cycle should result in reduction of medication costs per patient, reduction in nursing medication handling, reduction in medication errors, decrease drug wastage and pilferage, all of which will offset some of the increased costs associated with the new programs.

SUMMARY

After the publication of the GAO Report, Congress started appropriations for the unit dose conversion. From 1978 through 1981, several hospitals converted. From 1982 through 1984, the majority of the hospitals converted. The conversion funds then dried up.

Pharmacy Service - VA Dublin - converted three NHCU wards to a unit dose system in 1977 with no additional staffing. This was done so we would be knowledgeable in the unit dose system and would be prepared for the total conversion.

In 1984, it was indicated by Pharmacy Service CO that we (VA Dublin) were slated to convert to unit dose in 1985. Early in 1984, equipment monies were allocated to those facilites expected to be funded in FY 85. Pharmacy Service Dublin purchased all the equipment needed for the conversion. Limited UD conversion funds were available to CO in 1984. Conversion funds from CO then ceased in 1985. Our unit dose equipment was transferred to VA Leavenworth, Kansas, because of non-use.

RECOMMENDATION

Based on background information as cited, Pharmacy and Nursing Service at Dublin VA Medical Center strongly endorse the implementation of the unit dose system, to provide a more efficient and cost effective medication delivery system.

Benton F Corry

BENTON F. CORRY, R.Ph.
Assistant Chief, Pharmacy Service

Janet Crawford

JANET CRAWFORD, R.N.
Assistant Chief, Nursing Service

STATEMENT OF
WILLIAM R. HEAD
COMMANDER, DEPARTMENT OF GEORGIA
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
October 21, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than twenty-one thousand members of the Disabled American Veterans and its Ladies' Auxiliary within the Department of Georgia, and the more than one million members of this service Organization and its Ladies' Auxiliary nationally, I want you to know how much we appreciate the opportunity to present our views on the impact of the Veterans' Administration's budget situation on the delivery of health care to veterans living in rural areas, and on the status of the Surgical Service at the VA Medical Center, in Dublin, Georgia.

Mr. Chairman, the subject of today's hearings are uppermost in all VA Medical Centers. I will attempt to first cover the Surgical Service at the Dublin Hospital and second the funding of this Service.

1. SURGICAL SERVICE - The primary service area of the Dublin VAMC comprises approximately 35% of the total land area of Georgia. There are fifty-two counties and 110,000 veterans in this primary service area which is located in south central Georgia. This is truly a rural hospital with major consequence in continued high level quality care for our veterans. We have veterans coming from as far away as Albany, Georgia, a distance of 112 miles. It's hard to believe, therefore, that even the thought of closure should be entertained.

I understand that this panel is not looking at the quality of care issues, but in a sense you need to, not only here but in all VA Medical Centers. The quality of care in the Dublin Hospital has been excellent as evidenced in a report of the Medical District Initiated Peer Review Organization (MEDIPRO). Considering this portion of the MEDIPRO report thus leaves you looking at the budget restrictions. The Hospital as a whole operates 714 beds and had hopes of an additional 45 beds, 25 of those for the Domiciliary area, to provide increased inpatient and outpatient surgical care. This need must also be taken into consideration.

Without an inpatient surgical program the Dublin Hospital could not provide required surgical consultations. For example, the 29 patients who came the 112 miles from Daugherty County in Fiscal Year 1987, through June 1988, would have had to be transported the additional 100 miles to Augusta without compromising quality. Would this be possible? I doubt it.

Take inpatient surgery away and the accessibility and quality of care to the needy veterans of this south central area of the State are further reduced. Can we afford these reductions? I doubt that too.

A change of mission for this Hospital as well as the 9th Medical District would not meet the needs but only increase the problems.

Dublin's VAMC inpatient surgical workload has grown and continues to grow since 1986 as evidenced by the following figures:

	1986	1987	FY 88 thru June	Projected FY 1988
Discharges	630	613	477	636
Transfers	66	130	101	135
Patients Treated	679	651	579	772
TOTALS	1375	1394	1157	1543

The transfer figures shown are those patients transfered from surgery to another bed section and then discharged. While inpatient workload has increased since FY 1986, staffing has remained the same. The aging veteran population increase will not stop. The need for increased quality services to this area of the country will not end. Impact on the local economy is also a factor.

Disadvantages with losing surgical services at the Dublin Hospital would be many, and include but are not limited to:

1. Inadequate Community resources.
2. Increased travel for acutely ill veterans.
3. Erosion of quality care.
4. Increased beneficiary travel costs.
5. Inconvenience to the patient's family.
6. Reduced staffing for future affiliations.
7. Loss of jobs and decreased local sales.
8. Political factors.

Consider the following:

Surgical treatment would require transfers and the receiving facility would experience an increased workload, with adherent increased costs, and possibly prolonged hospitalization for completion of treatment. As for local backup, the Administrator of the Community Hospital has already stated that his Hospital's support is not available and that this is unlikely to change in the future. I submit to you Mr. Chairman that the Surgical Service at the Dublin VA Medical Center is of too great import to the veterans who fought for this great Country of ours to be cut because of budget restrictions.

2. THE FUNDING SITUATION - As a service Organization, this subject is out of our area at this level, however, being an old supply type, and being interested in manpower and equipment, one thing does come to my mind. What will happen to the doctors, nurses, and other employees who make up the surgical team of hospital workers, and the equipment which is already in place? Cuts in surgical service personnel and equipment would seem to provide a minimal relief to budgetary considerations.

One expensive piece of equipment, in the area of about a million dollars, a CT scan machine, is already sitting idle because of problems associated with recruiting a Radiologist. This problem exists because of the threat to loss of surgical services at the Dublin Hospital. This threat must be removed before other more serious cuts in service and thus further erosion of quality care take place. This threat must be removed before it causes additional quality medical or nursing personnel to turn away. This threat must be removed before its consequences invade the local economy.

Mr. Chairman, I trust that your Subcommittee will see the great need for continued Surgical Service at the Carl Vinson Veterans' Administration Medical Center in Dublin, for the 110,000 veterans, in the 52 county area of Georgia, serviced. I trust that you will recommend that this VAMC remain intact and that you will do all in your power to keep it that way.

One last thing. Mr. Chairman, I again wish to thank you and the members of your Subcommittee for allowing me as Commander, Department of Georgia Disabled American Veterans, to come before you to voice our views on the subject matter. We are grateful for your keen interest and that of Congressman G. V. "Sonny" Montgomery. On behalf of all veterans and their families, but particularly those in south central Georgia, thank you.

DEPARTMENT OF GEORGIA
FOUNDED 1899
VETERANS OF FOREIGN WARS
of the United States

STATEMENT OF

JOHN GWIZDAK, STATE COMMANDER
DEPARTMENT OF GEORGIA VETERANS OF
FOREIGN WARS OF THE UNITED STATES

AND

RICHARD BRANSON, STATE SERVICE OFFICER
DEPARTMENT OF GEORGIA VETERANS OF
FOREIGN WARS OF THE UNITED STATES

BEFORE THE

CONGRESSIONAL HEARING CARL VINSON VAMC
DUBLIN, GEORGIA, OCTOBER 21, 1988

WITH RESPECT TO BUDGET IMPACT ON THE
DELIVERY OF VA MEDICAL CARE TO RURAL
VETERANS IN THE STATE OF GEORGIA AND THE
PLANNING PROCESS RELATED TO CLOSING
SURGICAL SERVICES AT VAMC DUBLIN, GEORGIA

DUBLIN, GEORGIA OCTOBER 21, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to present the views of the Georgia Department Veterans of Foreign Wars of the United States with respect to the budget impact on the delivery of VA medical care to rural veterans in the state of Georgia and the planning process related to closing surgical services at the Carl Vinson VAMC Dublin, Georgia. We are pleased that your subcommittee demonstrates an active and deserving concern for the quality of medical care provided to our veterans, particularly in the state of Georgia.

The continuing budget reductions aimed at our VA medical facilities is most alarming and has, is, and will adversely and very seriously affect both the quantity and quality of medical care provided. Georgia is primarily

a rural state with more than 650,000 veterans. Approximately 48 percent of these veterans live in rural counties which are generally classified as medically underserved to the point of being impoverished. Since 1983, 61.5 percent of the total discharges for veterans residing in Georgia served by VAMCs Atlanta, Augusta, and Dublin, were veterans residing in rural areas. These veterans utilize VA medical care services at a much higher rate than those residing in metropolitan areas primarily because of reduced or inadequate medical facilities available in rural areas. Outpatient visits to Georgia VA medical centers have also significantly increased over the last few years by approximately 38 percent. This is primarily due to the emphasis being placed on outpatient care as an alternative to the more costly inpatient care. During recent years, 46.5 percent of these outpatient visits have come from veterans living in our rural counties. As these statistics point out, our rural veteran population relies upon and depends on the VAMCs for medical care which is now more than needed because of the aging factor. To date, the budget reductions for the VAMCs in Georgia have had a severe affect on personnel staffing, pharmacy services, repair and replacement of equipment, and the needed expansion and renovation of facilities. Without reservation Mr. Chairman, this trend in the degradation of available medical care provided to the men and women who served our great nation is not deserved and should be reversed and turned around now.

Mr. Chairman, we realize that discontinuing surgical services at VAMC Dublin, Georgia is only in the committee/planning stage at this time. However, the Georgia Department of Veterans of Foreign Wars of the United States goes on record now to inform your subcommittee that we strongly oppose curtailing any surgical services currently being provided by VAMC Dublin. Regionalization of services is not the answer. The end result

to our veteran patients would be to sacrifice the high quality and timely care that has been earned and should be due from a great nation. VAMC Dublin serves approximately 110,000 veterans. That number is sizeable and impressive. If surgical services are discontinued at this facility, there is nothing in the immediate area to handle emergency surgery requirements for our veterans and there is essentially no back-up available for other surgery. We do not believe that discontinuing surgical services at VAMC Dublin would increase efficiency for other VAMC surgical units in Medical District 9. It would be fallacious to assume that it would delete duplicating services. It is folly to suggest that it would redirect services and resources to a more cost-effective alternative. It is unrealistic to assume that a shifting of surgical resources from VAMC Dublin to higher priority areas would be economically prudent and the better part of wisdom. The inconvenience in travel, particularly under emergency conditions, and other sacrifices and the "people problems" generated should not be overlooked for they are real and human considerations. Mr. Chairman, the surgical services at Carl Vinson VAMC, Dublin, Georgia, must remain operational to serve our veterans in this rural part of the state. We urge your best efforts to preserve that privilege and thank you for all you do in that endeavor and in that direction.

STATEMENT

OF

A. V. "BUBBA" AKIN, DEPARTMENT SERVICE OFFICER

THE AMERICAN LEGION, DEPARTMENT OF GEORGIA

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THE AMERICAN LEGION, DEPARTMENT OF GEORGIA, IS APPRECIATIVE OF THIS OPPORTUNITY TO PRESENT ITS VIEWS ON THE PROPOSED CLOSING OF THE SURGICAL SERVICE HERE AT CARL VINSON V.A. MEDICAL CENTER , F.Y. 1988 BUDGET IMPACT.

BEFORE ADDRESSING SPECIFIC ITEMS ON THESE CONTROVERSIAL SUBJECTS, LET ME SAY THAT THE AMERICAN LEGION CONTINUES TO BE THE LARGEST VETERANS ORGANIZATION, NATION-WIDE AND HERE IN GEORGIA WHERE WE REPRESENT MORE THAN FORTY THOUSAND VETERANS OF THE FOUR AMERICAN WARS IN THE TWENTIETH CENTURY RESIDING IN OUR STATE. THAT BEING SO, WE BELIEVE OUR VOICES SHOULD BE HEARD IN ALL CRUCIAL MATTERS, AND WE APPRECIATE THE OPPORTUNITY THIS COMMITTEE NOW GIVES US.

MR. CHAIRMAN, I'M NOT HERE TO ATTEMPT TO QUOTE STATISTICS; SURVEY REPORTS AND VARIOUS PERCENTAGES. YOUR PANEL HAS THE EXPERTISE, AND MANY IN ATTENDANCE HERE ARE FAMILIAR WITH ALL ASPECTS OF OUR CURRENT ISSUES. THIS WAS WELL DEMONSTRATED BY YOUR CHAIRMAN MONTGOMERY'S RECENT PUBLISHED REPORT ON HEARINGS WITH ADMINISTRATOR TURNAGE ON INADEQUATE STAFFING: AND RESOURCES, SYSTEM-WIDE.

I WISH TO SPEAK FOR THE VETERANS INVOLVED IN THE T.A.G. PROPOSAL, AND FOR OUR AMERICAN LEGION GRASS-ROOTS; RURAL, POST-LEVEL SERVICE OFFICERS THROUGHOUT GEORGIA WHO DAILY MUST FACE AND COUNSEL ELIGIBLE VETERANS : THEIR FAMILIES: RELATIVES: LOCAL ELECTED OFFICIALS, AND YES, EVEN SOME CONGRESSIONAL STAFFERS WHO DEMAND EXPLANATIONS AS TO WHY IT IS DIFFICULT AND OFTEN IMPOSSIBLE TO OBTAIN ADMISSION TO A V.A. HOSPITAL. WE SERVICE OFFICERS KNOW, QUITE WELL, FROM HARD EXPERIENCE, THAT OPERATING BEDS HAVE BEEN REPEATEDLY REDUCED AND ARE JUST NOT AVAILABLE.

WE ALSO KNOW, MR. CHAIRMAN, THAT THE V.A. IS NOT MEETING IT'S LEGALLY MANDATED RESPONSIBILITY OF PROVIDING HEALTH CARE TO VETERANS.

AT OUR JULY NATIONAL CONVENTION IN LOUISVILLE, KY., THE ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR WAS ABRUPTLY CHALLENGED IN HIS REMARKS TO OUR VETERANS AFFAIRS COMMISSION SAYING THAT D.M.& S. WAS IN FINE SHAPE -- DOING MORE WITH LESS, EVEN WITH CURRENT BUDGETARY CONSTRAINTS. THE GOOD DOCTOR WAS THEN DELUGED WITH QUESTIONS; SOME IRATE COMPLAINTS AND CRITICISM FROM SERVICE OFFICERS, NATION-WIDE, CONCERNING CLOSURES: DENIED ADMISSIONS: INADEQUATE STAFFING OF NURSES AND TECHNICIANS AND OTHERS. THERE WAS NO SATISFACTORY REBUTTAL OFFERED BY THE CENTRAL OFFICE OFFICIAL.

AND, MR. CHAIRMAN, ONLY TWO WEEKS AGO OUR NATIONAL EXECUTIVE COMMITTEE MEETING IN INDIANAPOLIS, WAS BRIEFED ON PROJECTED D.M.& S. FUNDING SHORTAGES FOR THE CURRENT FISCAL YEAR AND I QUOTE " THE SHORTFALL IS EXPECTED TO FALL BETWEEN $ 800 MILLION AND $ 1 BILLION. IT IS INDICATED THAT THE V.A.WILL ATTEMPT TO ACQUIRE A SUPPLEMENTAL APPROPRIATION TO PROVIDE RELIEF IN THIS AREA. PROBLEM AREAS INCLUDE SEVERELY RESTRICTING CATEGORY B & C VETERANS : BED AND UNIT CLOSURES : RESTRICTION OF PHARMACEUTICALS; INCREASED WAITING TIME IN VARIOUS TYPES OF CLINICS, AND OTHERS "

WE OF THE LEGION ARE MUCH CONCERNED, MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE, THAT MANY OF THE 110,000 VETERANS LIVING IN THE 52 COUNTIES OF SOUTH-CENTRAL GEORGIA IN THE DUBLIN PRIMARY SERVICE AREA, HAVE NOW REACHED ADVANCED AGES WITH VARIOUS INFIRMITIES THAT ARE REQUIRING THEM TO SEEK MEDICAL TREATMENT AND CARE FOR THE FIRST TIME. THIS URGENT AND INCREASING NEED IS CREATING A TREMENDOUS DEMAND ON THE V.A. HEALTH CARE FACILITY HERE AT DUBLIN, AS WELL AS ATLANTA AND AUGUSTA, WHERE ADMISSIONS ARE ALMOST IMPOSSIBLE UNDER PRESENT CONDITIONS. THIS DEMAND, REGARDLESS OF VARYING OPINIONS, IS COMPOUNDED BY THE FACT THAT THE GREATER MAJORITY OF OUR VETERANS SEEKING SURGICAL AND OTHER MEDICAL TREATMENT HERE, ARE INDIGENT AND UNABLE TO PAY FOR NEEDED MEDICAL CARE IN THE PRIVATE SECTOR.

AS ACTIVE SERVICE OFFICERS WE ARE CONVINCED THAT DECREMENTAL BUDGETING HAS HAD AN ADVERSE EFFECT ON PATIENT CARE, BOTH IN-PATIENT AND OUT-PATIENT AND WILL CONTINUE TO ERODE THE QUALITY: QUANTITY AND TIMELINESS OF HEALTH SERVICES PROVIDED OUR VETERAN-BENEFICIARIES. WE HEARTILY AGREE WITH YOUR CHAIRMAN IN HIS PRAISE AND COMMENDATION OF LOCAL ADMINISTRATIVE AND MEDICAL STAFFS, SYSTEM-WIDE. HE STATES THAT THEY ALONE

DESERVE THE ACCOLADES AND THAT LOCAL MANAGEMENT HAS KEPT VETERANS HEALTH CARE SOLVENT IN RECENT YEARS. MR. CHAIRMAN, AS YOU KNOW, WE PROCLAIM THAT TO BE TRUE HERE AT DUBLIN.

THE AMERICAN LEGION URGES YOU TO ASSIST IN TOTAL REJECTION OF ANY PROPOSALS OR RECOMMENDATIONS OF THE REGIONAL TASK ADVISORY GROUP (T.A.G.) TO CLOSE SURGICAL SERVICE AT THIS MEDICAL CENTER. MIDDLE GEORGIA VETERANS CAN ILL-AFFORD TO LOSE THIS NEEDED MEDICAL CARE FOR WHATEVER REASONS. AND FURTHER, WE SINCERELY REQUEST THAT CONGRESS COMMIT THEMSELVES TO PROVIDING ADEQUATE FUNDS TO ASSURE THAT ALL AUTHORIZED BEDS ARE FULLY STAFFED: OPERATIONAL AND READILY AVAILABLE.

OUR NATIONAL LEADERSHIP WILL CONTINUE TO EMPHASIZE THE NEED FOR ADDITIONAL RESOURCES FOR THE V. A. HEALTH CARE SYSTEM. SECURING THESE ADDITIONAL RESOURCES WILL BE AT THE FOREFRONT OF OUR LEGISLATION INVOLVEMENT WITH THE 101ST CONGRESS.

WE, TOO, ARE MOST CONCERNED ABOUT THE V.A. LEADERSHIP'S CONTINUING EFFORT TO DISGUISE REALITY, AND DO NOTHING TO REMEDY WHAT IS WIDELY RECOGNIZED AS A CRISIS IMPOSED UPON OUR VETERANS BY THE OFFICE OF MANAGEMENT AND BUDGET.

IN CLOSING, THE AMERICAN LEGION, DEPARTMENT OF GEORGIA, DOES NOT SEEK MORE FROM THE FEDERAL GOVERNMENT THAT WE BELIEVE ARE THE JUST DUES OF THE MEN AND WOMEN FROM OUR STATE WHO HAVE ANSWERED THE CALL OF THE ELECTED GOVERNMENT TO DEFEND THE NATIONAL INTEREST IN THE ARMED FORCES.

WE KNOW WELL THE DEDICATION AND INTEREST OF THE CHAIRMAN AND MEMBERS OF THIS SUBCOMMITTEE AND OF THE FULL COMMITTEE ON VETERANS AFFAIRS IN ENSURING FOR THE LEGITIMATE NEEDS AND CARE OF OUR DISABLED AND SICK VETERANS. WE COMMEND YOUR DEDICATION AND EFFORTS.

THANK YOU, AGAIN, FOR THE OPPORTUNITY TO PRESENT OUR VIEWS.

STATEMENT
OF

THOMAS E. GRABOWSKI, PRESIDENT
CHAPTER #404, AIR FORCE SERGEANTS ASSOCIATION

and

JUDITH C. GRABOWSKI, PRESIDENT
CHAPTER #A404, AIR FORCE SERGEANTS ASSOCIATION AUXILIARY

TO THE SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE COMMITTEE OF VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

October 21, 1988

Recently we were informed that a Congressional panel was planning to hold hearings on 21 October 1988 at the Carl Vincent V.A. Medical Center to determine what impact closing the surgical service there would have on the quality of care, and access to care for the Veteran population in the DUblin V.A. primary service area.

As registered VAVS volunteers, and Presidents of the Air Force Sergeants Association--Chapter 404 and Auxiliary Chapter A 404, we wish to address this issue, and the tremendous negative impact it would have on patient care.

We're sure most members of this panel are aware that the Dublin facility services 52 counties and over 110,000 veterans.

The recommendations by the VA Regional Advisary Committee for Region 9 calling for the closing of the impatient surgical unit, as an economy measure is-----in the politest term we can find----ABSURD!

Taking away a benefit from thosewho have earned it, by paying a price most would find next to impossible to pay--is NOT THE ANSWER.

Surgical consultation is vital and ofter times is required in a matter of minutes, 24 hours a day, 7 days a week with follow up by the surgeon. How can we ask those veterans who may require this immediate care to be expected to face a 3 or 4 hour ride to another facility for consultation and treatment? In cases of scheduled surgery--the waiting period would be long and in many instances require the services of a nurse to travel with the patient--not really cost effective.

If the surgery program is removed, patients would suffer (some even die), physicians would leave, accute medicine would ultimately close, and at best reduce the Dublin facility to a nursing home and mental health facility (and then only with limited capability).

We don't need or want another nursing home in the immediate or surrounding area-we need the full service hospital we have in Dublin.

The excellent patient care we"ve experienced over the years we've been connected with the Dublin VA Medical Center, in addition to the positive happy attitude of the patients, staff and volunteers, certainly must show this committee that quality care, and patient concern are the primary mission of this medical center.

The very fiber of our great country is founded upon the principles of life, liberty and the pursuit of happiness.

Can you, or anyone, comfortably endorse a program which threatens our most cherished entitlement, life?

The congress and the American people have traditionally demanded quality medical care for our veterans. The proposal to close the surgical services at the Dublin VA Medical Center would without question, not only violate this mandate, it would destroy it.

At a time in their lives when medical attention and care are critical, the verterans ask only the same consideration they rpovided when they performed their service...quality, availability, expediancy and professionalism. There was never a time during their tenure they discussed---what impact cutting down their services would have on the American people---they gave their full measure, and often a touch more, and far too many paid the ultimate price--but those remaining still carried on and provided what they know this country expected--complete dedication to "Americans taking care of Americans". Can we offer anything less?

Thomas E. Grabowski

Thomas E. Grabowski/Pres. Chapter 404
Air Force Sergeants Association

Judith C. Grabowski

Judith C. Grabowski/Pres.Chapt/A404
Air Force Sergeants Assoc. Aux.

STATEMENT OF CURTIS D. SMITH, VICE-PRESIDENT
GEORGIA-CAROLINA PARALYZED VETERANS OF AMERICA

TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

October 21, 1988

Mr. Chairman and Members of the Subcommittee:

The Paralyzed Veterans of America is grateful for this opportunity to express its concern regarding the budgetary shortfall for the Veterans Administration and the recommendation to remove Surgery Service from the Carl Vinson VA Medical Center.

First, since fiscal year 1989 is now underway, we have been aware of the serious budgetary shortfalls at all VA Medical Centers. The PVA has received numerous complaints regarding short staffing, low morale, inadequate funds for medical supplies--especially for the pharmacies, and funds withdrawn from the medical centers for the one percent productivity incentive, workload reductions and the Gramm-Rudman-Hollings reductions.

As a patient at this medical center for over 20 years, I have personally witnessed the staffing shortages and have known many frustrated medical professionals who have left the VA for better paying jobs and benefits elsewhere.

Also, as you can see, I'm totally dependent upon the medical staff and the VA to do almost everything for me. The importance

of maintaining adequate funding, appropriate staffing and maintaining the highest quality of health care is very critical to me as well as to my organization's members whom I represent here today.

Secondly, I would like to address the issue of the possible removal of Surgical Service from this medical center.

For a number of years I have heard that this medical center would be converted to a long-term care and nursing home care facility. Although these have been rumors, closing the Surgical Service will prove these rumors to be true. Closing this service to the more than 110,000 veterans of south/central Georgia would be a detriment to the high quality of medical care provided by the VA Medical Center here. This high quality of medical care is the number one reason why Surgical Service must not be closed. We must have an incentive to recruit and retain health care professionals. Without surgery, these highly trained health care professionals would soon transfer to other VA facilities that would use their specialties. These health care professionals depend upon the backup support from Surgical Service which requires the expertise in surgical procedures. Without surgery, these procedures could not be done. Without these procedures, the health care professionals are unable to maintain their expertise and skills needed to properly diagnose the patients' conditions. Without these skills, the health care professional becomes incompetent. We don't want that to happen to anybody.

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Another point I would like to comment on is the transportation of seriously-ill patients to other VA medical facilities for surgery. It's not practical and would prove to be very costly, not only in dollars, but in the life of the veterans. There is a 5-hour round trip travel time from Dublin to Augusta and Atlanta and even longer to Charleston and Columbia, South Carolina. This does not take in account the waiting time and the workups needed in their surgical clinics before surgery is even performed. All of this traveling and waiting will cause extreme hardships and complications for an already seriously-ill patient. There is even the possibility of death to the veterans while they are being shuffled around between facilities.

Traveling will also interfere with the timely treatment of veterans. The VA Medical Center should be able to treat all veterans who apply for medical care with the very best care, with the very best staff available, and in the most cost effective way. Surgical Service in Dublin has proven to be a very cost effective operation.

Therefore, instead of a reduction of services, Surgical Service should be expanded to include other areas such as orthopedics and ophthalmology. These specialties are needed more and more because of our aging veterans.

In conclusion, the Paralyzed Veterans of America has expressed

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the importance of maintaining adequate funding levels for the VA health care programs. Today, we are witnesses to an ever increasing level of frustration from not only the veteran beneficiaries of an aligning health care system but from health care professionals who have to maintain this high quality of care with a decreasing amount of resources. I sincerely trust that the VA officials have explained the true extent of the problems being experienced in the VA medical care system and that they have accurately portrayed the budgetary and surgical requirements of the Carl Vinson VA Medical Center in Dublin.

Again, thank you for the opportunity to express our concerns.

Mr. Chairman and members of the subcommittee, this concludes my statements.

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United States Senate
COMMITTEE ON ARMED SERVICES
WASHINGTON, DC 20510-6050

December 1, 1988

The Honorable G. V. Montgomery
U.S. House of Representatives
Committee on Veterans' Affairs
Washington, D.C. 20515

Dear Sonny:

Thank you for your recent invitation to participate in the field hearing which your Subcommittee on Hospitals and Health Care will be holding on December 1, 1988, in Dublin, Georgia. I regret that prior travel commitments preclude me from participating personally in this important hearing. However, I have directed my staff to attend and apprise me of the testimony from the many qualified witnesses who will participate.

Quality, accessible health care for our veterans is an important issue. Despite the budgetary constraints which the Veterans Administration faces, I believe that quality health care must receive priority consideration. The prospective closure of the surgical unit at the Dublin VA Center represents a step back from our nation's commitment to our veterans. This proposal merits very careful scrutiny.

Almost one half of all veterans live in rural areas. Because of the age and medical condition of many veterans, I do not believe that it is realistic to expect them to travel long distances to receive the medical care which they so richly deserve. This is why the matter of accessibility is almost as important as the quality of care. For many veterans, lack of access actually means that no care will be provided.

My hope is that the Dublin field hearing will clarify the plans of the Veterans Administration regarding the provision of health care to rural areas such as Middle Georgia. I believe that careful assessment of both the VA's priorities and the options available within local communities needs to be fully explored before any final decision is made on this matter.

As always, the veterans of America are indebted to your leadership and that of Congressman Roy Rowland for addressing this matter.

Sincerely,

Sam Nunn

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October 20, 1988

Dear J. Roy:

It upsets me that the VA is considering closing the Surgical Service in the Carl Vinson Medical Center in Dublin, Georgia. This center has a primary service area of fifty-two (52) counties in Central Georgia and this represents a veteran population of one hundred and ten thousand (110,000). Many of these veterans would not be able to drive to Atlanta or Augusta due to increased mileage but now can either drive this distance or be transported here by relatives or friends. The fiscal year 1987-1988, which ended this September, shows that our local VA Medical Center treated five thousand three hundred sixty-four (5,364) inpatients and fifty-five thousand and sixty (55,060) outpatients.

Should the Surgical Service be closed Internal Medicine would be unable to perform certain procedures or consult about the performance of many diagnostic procedures. This would result in patients deprived or delayed by referral for these procedures.

At the present time, the Surgical Service enjoys a good reputation in the local area and among the veteran population and they feel that this is a full service hospital. The Physical Therapy and Correctional Therapy departments are quite good and rated over the same services at VAMC of Augusta by the veteran population.

If surgery is contracted to be performed locally at Fairview Park Hospital, veteran cases would probably be placed at the end of the schedule and those performing surgery would be tired physicians, nurses, and other medical personnel. The "One Day Surgery" procedures would be handled in a similar manner, I feel sure. Also the fees for these procedures would be quite costly. This would be followed by stays in ICU or CCU for several days. At the present, good post-operative "follow-up" by physicians and nursing care is excellent. Also there is always the question, "Would veterans for emergency procedures be treated quickly and adequately in the local hospital?". The question of medical liability might rear its ugly head if this type procedure is followed.

I attended the Medical College of Georgia 1947 through June 1951 when Lenwood VA Hospital was the only facility for veterans in Augusta and since it was primarily a psychiatric hospital it was locally known as "The Looney Hospital" and somewhat shunned by veterans if possible. Also the local people looked down upon a predominantly psychiatric hospital and that somewhat still remains a stigma. If the Carl Vinson VAMC remains a full service hospital with surgery it will be considered much more highly and also be able to secure better and more physicians for this hospital.

I feel that the Carl Vinson Medical Center will continue to secure well qualified physicians in specialities other than surgery so long as we have a good active department of surgery. In the end the people who will be severely short-changed will be the veterans of the Central Georgia area served by this hospital.

Yours truly,

Seab